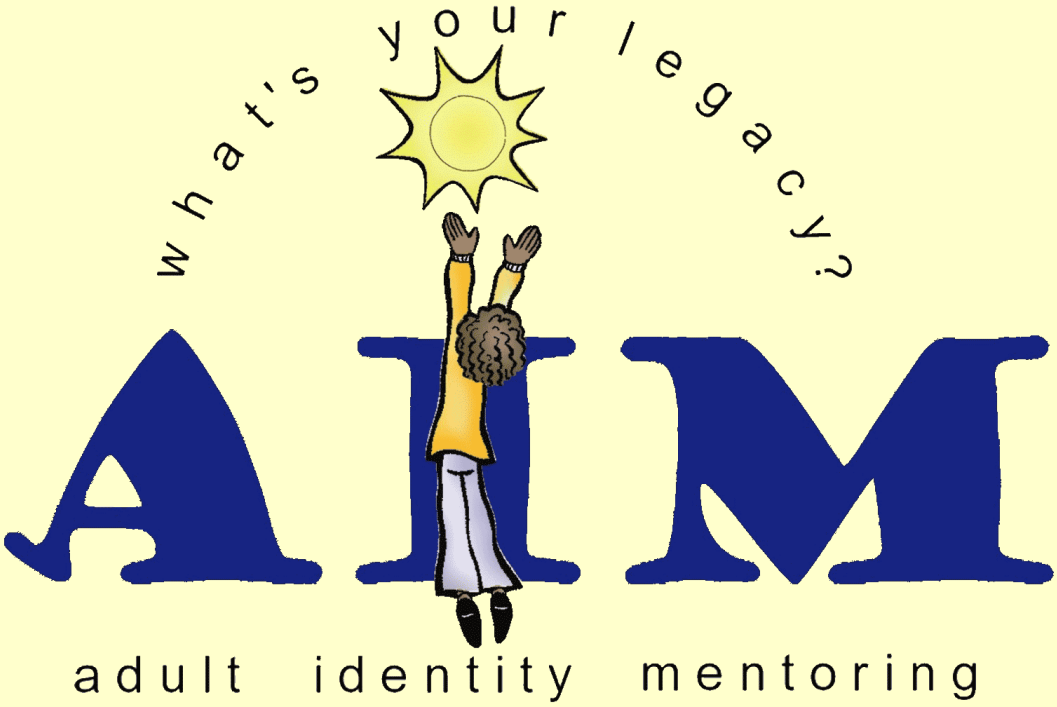
Project AIM

An evidenced-based program to reduce HIV sexual risk behavior among adolescents



Implementation & Monitoring and Evaluation Guide

Acknowledgements

The original implementation research was done by Leslie F. Clark, Ph.D. (Children's Hospital of Los Angeles) and Kim S. Miller, Ph.D. (Centers for Disease Control and Prevention). It was supported by the Centers for Disease Control and Prevention, (#U64/CCU41327).

The research outcomes are published in:

Clark LF, Miller KS, Nagy SS, Avery J, Roth DL, Liddon N, Mukherjee S. (2005) Adult Identity Mentoring: Reducing sexual risk in African American seventh grade students. *Journal of Adolescent Health, 37*(4), e1-e10.

TABLE OF CONTENTS

This manual is designed to support your organization in implementing *Project AIM.* It provides an overview of the intervention and the changes made to the original intervention to make it appropriate for South Africa. It includes guidance on what is necessary to be successful in your implementation process. There are also a series of useful materials included in the appendix. The following is a brief overview of the sections of the manual.

Section I:
Project AIM Introduction and Background

Section I, introduces you to *Project AIM*. It provides background information on the goals of the intervention. It includes supporting information on how the program works to reduce risk behaviors among adolescents. It also includes descriptions of each session and results of the original research.

Section II:
Project AIM in South Africa

Section II provides the rationale for using *Project AIM* in South Africa. It describes the adaptations that were made to make the intervention culturally and linguistically appropriate for use in South Africa.

Section III:
Requirements for Successful Implementation

In Section III, you will find information on requirements and preparations that should be made prior to implementation. It includes staffing and equipment needs, suggestions on logistics and materials, and a sample budget.

Section IV:
Getting Started with Implementation

Section IV provides guidance on marketing the intervention, training and certifying facilitators, and recruiting and retaining participants. It includes information on consent, ethical issues, attendance, and assuring the quality of the intervention.

Section V:
Monitoring and Evaluation of Project AIM

This section serves as a guide for how to monitor and evaluate your organization's *Project AIM* intervention. It guides you through data collection activities used to assess whether your organization is meeting the program objectives established for *Project AIM*.

Section I:
Project AIM Introduction and Background

Goal and Overview of Project AIM

The goal of *Project AIM* is to reduce sexual risk behaviors among adolescents between the ages of 11 and 14 by providing them with the motivation to make safe choices and to address deeper barriers to sexual risk prevention (e.g., hopelessness, risk opportunities in low-income environments). *Project AIM* is a group-level, adolescent development intervention based on Markus' Theory of Possible Selves. This theory states that a person's motivation is determined by a balance of positive and negative ways people see themselves in the future. Individuals who are able to imagine both possible positive and negative futures are more likely to work toward their life goals and achieve future success. Thus, *Project AIM* encourages adolescents to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood.

How Project AIM Helps Adolescents

Project AIM is different from other HIV prevention programs. Historically, programs to prevent HIV risk behaviors in adolescents have taken one of two approaches: an abstinence-based approach or a comprehensive sexuality education approach. The goal of abstinence-based programs is to delay the initiation of sexual intercourse or to stop having intercourse for adolescents who have already begun. Activities in these programs address refusal skills and norms for waiting to engage in sexual activity. The challenges to these programs are the lack of evidence that they are effective in getting adolescents to abstain.

Comprehensive sexuality education approaches also try to encourage adolescents to abstain but are based on the idea that while some adolescents may engage in sexual intercourse we can still reduce the harm by promoting the use of condoms or reducing the number of sex partners that an adolescent has. These programs are generally based on Social Behavioral Learning Theories and include activities such as condom use skills and condom negotiation.

Project AIM affects change in sexual behavior without focusing explicitly on sexual risk. *Project AIM* is based on a motivational theory that engages adolescents in activities that reduce their engagement in risky behaviors. It is designed to encourage young people to think about their desired future and how current risky behavior choices can adversely affect it.

Research Results

Project AIM was tested among a group of 7th graders in the United States. Surveys about sexual activity were conducted before the intervention and 12 weeks and one year after the intervention ended. Results of the US-based *Project AIM* showed that the intervention was effective in:

- Reducing intentions to engage in sex
- Delaying sexual initiation
- Increasing sexual abstinence
- Improving school performance (behavior and grades)

Students who received *Project AIM* showed sexual risk reduction and increased sexual abstinence compared with students not receiving *Project AIM*. *Project AIM* effects on abstinence remained for male students one year after they finished *Project AIM*.

How Project AIM Works

Project AIM is comprised of twelve 50-minute sessions delivered to groups of 10 to 18 adolescents by 2 certified facilitators. The intervention is divided into four parts.

Project AIM Session Descriptions

The *Project AIM* curriculum is divided into four parts. Each session has key objectives, aims, and overall purpose.

Part One: Legacy, Role Models, & Peers

Part One consists of Sessions 1-4. The overall objectives of Part One are as follows:

- To prepare adolescents to think ahead to their future.
- To encourage adolescents to examine the ways in which their choices affect their future success.
- To encourage adolescents to examine the ways in which others influence their future success.

Session 1: What is a Legacy? (50 Minutes)
Introduces the *Project AIM* (Adult Identity Mentoring) program. Adolescents discuss the concepts of what it means to create a legacy for oneself, the importance of having a goal for one's future, and begin to think about their own future selves.

Session 2: Looking Ahead to My Future (50 Minutes)
Adolescents are encouraged to look ahead and envision their future. They will practice self-confidence strategies to help them prepare for a positive future.

Session 3: Guest Speakers (50 Minutes)
Young adults who have professional experience visit to share

with adolescents how they overcame obstacles, and how they had to prepare for their future. Adolescents engage in
note-taking, discussion, and the writing of a thank you letter to the Guest Speaker.

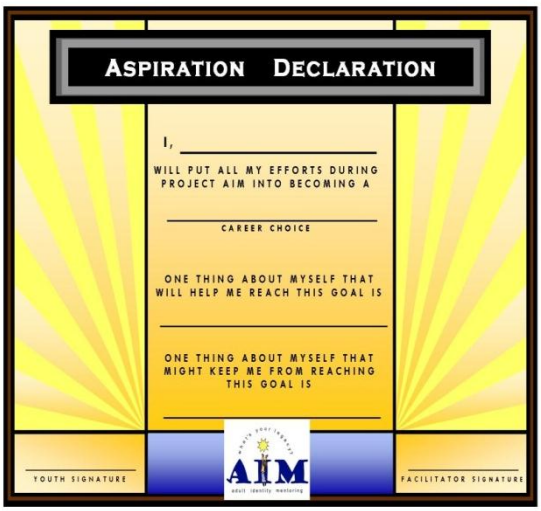
Session 4: What Lifts Me Up, What Holds Me Back? (50 Minutes)
Adolescents identify people in their lives that can help them or hinder them in achieving a positive future self. Adolescents discuss the influence that others have upon their lives.

Part Two: Exploring My Future
Part Two consists of Sessions 5-8. The overall objectives of Part Two are as follows:

- To encourage adolescents to choose a future career to focus on in their *Project AIM* activities.
- To understand the need to reach out to people who are important in helping you achieve your goals.
- To create products (business cards, CV or resume) that allow adolescents to see themselves as achieving that future career.

Session 5: Expressing Myself in My Future Career (50 Minutes)
Adolescents assess their own interests through a Career Rainbow interest inventory to help them identify possible future careers.

Session 6: Exploring My Future (50 Minutes)
Adolescents receive Career Reports based on their inventory scores. Adolescents identify a career choice for the program and make a public declaration of their choice.



Session 7: What Does Today Have to Do with My Future? (50 Minutes) Encourages adolescents to consider the ways in which their current behaviors and activities affect their possibility of success in the future. Each adolescent will prepare a personal CV or resume. Adolescents will discuss activities within their school and community that they could pursue and those that they should avoid.

Session 8: What Can I Do NOW to Get There?
(50 Minutes)
Adolescents will discuss activities they can do now to prepare for their future and help them achieve their goals. Each adolescent will design business cards to showcase their Future Career.

Part Three: Expressing Yourself
Part Three consists of Sessions 9-10. The overall objectives of Part Three are as follows:

- To learn how to communicate clearly and effectively to make good things happen and to avoid getting involved in activities that will not lead to future success.
- To create a plan for a future home.

Session 9: Expressing Myself in Communication and Relationships (50 minutes)
Addresses negative peer pressure and its possible impact on one's goals for the future. Adolescents participate in role-play activities around passive, aggressive, and assertive communication styles and how to express themselves in difficult situations more effectively.

Session 10: My Dream Home (50 Minutes)
Uses planning and decision-making skills. Adolescents apply skills learned so far in *Project AIM*, including visualizing a goal, and developing a strategy to achieve a goal.

Part Four: Choosing My Future
Part Four consists of Sessions 11-12. The overall objectives of Part Four are as follows:

- To engage adolescents in long range planning for their future.
- To address obstacles that may challenge adolescents' ability to achieve their future goals.

Session 11: Choosing My Future (50 minutes)
Provides the opportunity for adolescents to think about their future in terms of milestones and steps to accomplishing major life goals. After consideration of potential obstacles that they may face in life, they will develop a timeline for their life, and plan their next steps for secondary school and beyond.

Session 12: Putting It All Together (50 Minutes)
Adolescents will compile their portfolios and reflect on their Project AIM accomplishments. Adolescents will celebrate and experience their success in the program.

Core Elements and Key Characteristics

Core Elements
Core elements are required elements that embody the theory and internal logic of the intervention and are thought to most likely produce the intervention's main effects. Core elements essentially define an intervention and must be kept intact (i.e., with fidelity) when the intervention is being implemented or adapted, in order for it to produce program outcomes similar to those demonstrated in the original research.

There are two types of core elements: content and delivery. Content core elements are the elements of what is being taught that are believed to be responsible for the behavior change. Delivery core elements relate to the logistics of the environment and refer to how

the content is being delivered which reflects the theoretical framework of the intervention. *Project AIM* has the following 8 core elements.

Content Core Elements

1. Engage adolescents in thinking about a positive possible future self. Help adolescents:

- **Look ahead** to the future as successful adults.
- **Envision** a positive future self.
- Engage in **goal setting** to achieve a positive future as an adult.
- **Articulate** the specific details of a positive future self.

2. Engage adolescents in present actions to achieve future success. Help adolescents:Develop skills to achieve effective **communication**.

- **Identify** strengths and the resources needed for future success. **Experience** success to reinforce adolescents' positive future self.

3. Encourage adolescents to **safeguard** the future through risk reduction. Help adolescents:
   - Develop strategies to safeguard the likelihood of a positive future self through risk reduction and a balance of their future possible positive and negative selves. The content core elements of Project AIM spell out the word "legacies".

Delivery Core Elements

4. Use two trained and certified facilitators whom adolescents find credible to deliver *Project AIM*.

5. Deliver multiple intervention sessions, with sufficient time between sessions for adolescents to process information they are learning, draw conclusions, and invest in their goals.

6. Have adolescents create a compilation of their work representing their positive future, possible future self, and the activities to achieving that possible future self.

7. Deliver activities in ways that support adolescents with enthusiastic positive feedback that focuses on their individual strengths.

8. Deliver to adolescents ages 11-14 living in challenging environments.

Key Characteristics

Key characteristics are important, but not essential, attributes of how an intervention is delivered and its recommended activities. They may be modified to be culturally appropriate and fit the risk factors, behavioral determinants, and risk behaviors of the target population. They may also be modified to fit the unique circumstances of the venue, organization, and other stakeholders. Modification of key characteristics should not

compete with or contradict the core elements, theory, and internal logic of the intervention[1]. *Project AIM* has the following key characteristics:

1. The optimal group size is between 10-18 adolescents. For a larger group size, it is recommended to have an assistant work with the facilitators to help with the out of session tasks.

2. It is recommended that facilitators are young adults from backgrounds similar to adolescents, preferably one male and one female, AND able to relate/interact positively with adolescents.

3. Session length is 50 minutes. However, sessions could be extended to accommodate for more in-depth discussions about key concepts and/or to facilitate supplemental activities that reinforce the core elements.

4. Guest speakers share their experiences working towards a positive future and the challenges they may have encountered.

5. Project AIM uses the Career Rainbow to match adolescents' interests to career possibilities.

Theory Behind Project AIM: Theory of Possible Selves

The Theory of Possible Selves offers a new approach to HIV prevention by focusing on adolescents' desires and motivations for attaining adulthood goals. In brief, the theory asserts that behavior change is motivated by both what adolescents hope to become (positive possible future self) and what they wish to avoid becoming (negative possible future self). *Project AIM* promotes the capacity of at-risk adolescents to persevere in their efforts to attain a positive future and to avoid risk behaviors that would endanger the success of a positive future adulthood.

The more clearly adolescents can envision and communicate the positive future selves (their hopes, goals, and dreams), the more attainable (or real) they seem and the more motivated adolescents become to achieve them. The more adolescents imagine a negative future, the more they may believe it will come true, and the more hopeless they feel. Being in jail, addicted to drugs, and homeless are some examples that adolescents may envision of a negative future. In communities of poverty, adolescents are often overwhelmed by images of the negative future possible selves based on what they see around them in their immediate environment.

It is important for adolescents to have a balance of images of both positive and negative potential futures. If adolescents envision only positive future selves, they may not accurately gauge their chances at success, or properly prepare themselves for obstacles, setbacks, or short-term disappointments. On the other hand, with only negative future selves in mind, there is no belief that a positive future is possible, no plans for the future,

[1]McKleroy, V., Galbraith, J., Cummings, B., Jones, P., Harshbarger, C., Collins, C., et al. (2006). Adapting evidence-based behavioral interventions for new settings and target populations, AIDS Education and Prevention 18 (Suppl. A):59-73.

and no motivation to pursue long-term goals.

It is a balance of both positive and negative future images that makes adolescents most likely to persevere in efforts towards achieving goals. Therefore, enhancing a young person's ability to envision a positive possible future self, while also envisioning a negative possible future self, motivates the young person to make healthier choices in the present.

Contributing Concepts to Project AIM Success

Future into Present
Part of *Project AIM*'s success is due to how the materials are put together and how it encourages adolescents to bring their future to the present. *Project AIM's* activities make positive possible futures concrete for adolescents. The activities bring the adolescents' possible positive future selves into the present through the generation of business cards, guided imagery, and developing a timeline. In addition, there are activities (*It's My CV, Planning My Next Steps, and What Can I Do Now to Get There?*) that provide them with opportunities to think about what they can do now and to plan their next steps towards achieving their future goals**.**

General to Personal
Project AIM also goes from the general to the personal in a non-threatening way. The activities achieve consensual buy-in through group discussions. Then, adolescents complete individual worksheets, which make concepts personal and allow adolescents to take a position on their own choices.

At this age, often when adolescents are asked to join in the discussion, many adolescents will say "I don't know" and part of what they are saying is "I don't even know how to get to the point where I would know. I don't know because I don't think about it." Adolescents often tell facilitators "No one has ever asked me about what I want for my future before". Thinking about their future can be a new skill for adolescents and *Project AIM* activities lead them to build this skill.

Abstract to Concrete
The cognitive abilities of adolescents this age suggest that some may not fully grasp something as abstract as a hypothetical future. *Project AIM* is designed to bring abstract concepts into something very concrete. In one activity adolescents are asked to put together their business cards. This activity is an example where adolescents create something very concrete that is helping them to see what they might be in this hypothetical future. The business cards also help them see that expressing their good qualities related to the career choice can come through the font and design of the card-- creative, serious, bold, or responsible-- and doing this can increase their likelihood of success. These concrete details also help them make the possible future self appear more real to them.

The letter of recommendation, the CV or resume, and the timeline, all accomplish similar things. The more real the vision of the positive possible future self, the more powerfully it can motivate adolescents.

Incidental versus Intentional Learning
Research has shown that incidental learning—acquiring information when one is trying to do something else -- is a more powerful way to learn than intentional learning, for example lectures and testing on topics. It is easier to learn a language when living in that country and to learn about car engines through hands-on experience. Incidental learning is not only a great way to learn, it is a very powerful way to change people's attitudes. Engaging adolescents in tasks and allowing them to learn through activities is something that is built into *Project AIM*.

Identity exploration begins in early adolescence. Many communities lack resources to provide their adolescents with sufficient avenues for positive, constructive exploration. Even within schools, due to lack of resources and the academic focus, there are few opportunities for adolescents to develop other talents and receive the necessary reinforcement in this regard. Arts, work experience, and politics often are not available until secondary school or later.

Many young people also feel that a pathway is set for them. Some are convinced by the time they are 12 that they have few options for what they can become in the future. In the original research, there were a lot of kids at 12 who said they were going to become doctors, yet they were making poor grades in school. Even though they may have a goal, they may not have a connection to the reality of how to achieve that goal. *Project AIM* is constructed to address all of these issues.

adult

identity

mentoring

Adolescent Development
Adolescent development programs promote healthy adolescent development and resilience through positive activities that encourage appropriate, age-relevant skills and attributes. *Project AIM* is considered to be an adolescent development approach. The strategies and activities that are used in *Project AIM* protect them from engaging in risky behaviors and also foster important aspects of adolescent development such as:

Adolescent Development Constructs	Project AIM Strategies & Activities

Clear and positive identity	*Project AIM* enhances adolescents' articulation of future self through interest inventories, business cards, and CVs or resumes. Adolescents conduct self-examination of their strengths, talents, interests, needed resources, and are encouraged to perceive themselves as one who is on the path to success.
Belief in the future	Based on the theory of possible selves, *Project AIM* activities require adolescents to see themselves in terms of succeeding in their future; and in terms of the future as holding opportunities that will enable them to succeed in life.
Self-determination	Adolescents are asked to consider how their behaviors might promote or impede the achievement of desired future self-identities. There are peer discussions about risky behaviors, creating choices in their futures, and making decisions about what they want in life.
Self-efficacy	Adolescents engage in role-playing different styles of communication (aggressive, passive, and assertive) to practice self-expression and resist peer pressure. Facilitators conduct individual interviews with adolescents to enhance adolescents' communication skills and help them identify their strengths and resources to increase the likelihood of future success.
Pro-social norms	The use of small group and role models (guest speakers and facilitators) create and sustain group norms of delaying or abstaining from sexual activity and other behaviors that could disrupt achievement of their goals.
Behavioral and social competences	*Project AIM* promotes skills in positive self-presentation such as writing business cards, CVs or resumes, decision- making and planning skills, interview skills, relationship skills, and self-expression skills. Adolescents identify the role of family, peers, and others in supporting or negatively impacting their future success.
Positive emotions	*Project AIM* activities encourage a sense of hope for the future, pride in attributes of themselves, and creative self-expression.

Resiliency	*Project AIM* includes activities around withstanding peer pressure communicating with peers, accessing resources, connecting with positive adults in their lives and overcoming obstacles.

Project AIM's efficacy to change adolescents' behaviors is due to the holistic approach of applying the theories of motivation towards helping adolescents with adult identity exploration, a task developmentally associated with adolescence. The overall objective of *Project AIM* is more than changing a specific sexual behavior. *It's about offering alternative positive choices to defining themselves as successful adults and providing them with actual opportunities of achieving success within the program.*

Section II: Project AIM in South Africa

Rationale for Project AIM in South Africa

Research has shown South African adolescents to be involved in a variety of risky behaviors. Many more adolescents are being exposed to risk opportunities in low-income environments which may impact their immediate and future health and well-being.

One of the risk behaviors young people in South Africa engage in is early sexual activity. Research indicates that between 10-13% of young people start having sex before age 15 (HSRC, 2009; MRC, 2010). Almost 2 times more males than females are sexually active before age 15 (HSRC, 2008 in HSRC, 2009). Approximately two thirds (67%) of young people aged 15–24 years reported having had sexual intercourse. Among adolescents who reported ever having had sex, the mean age of first sex for males was 16.4 years and 17 years for females (RHRU, 2003).

According to the United Nations Population Fund (UNFPA), pregnancy is a leading cause of death for young women 15–19 years old. Young women in this age group are twice as likely to die during childbirth as women over 20 years old; girls under 15 years old are 5 times as likely to die (UNFPA, 2010). Research shows that by age 18 years, 20% of women in South Africa have given birth to a child and by age 20 years more than 40% have become mothers (HSRC, 2005). Of grades 8–11 learners, 18% indicated that they had a child of their own (MRC, 2010). Furthermore, almost two thirds of teenage pregnancies are neither planned nor wanted, with the father of the child seldom taking responsibility for the financial, emotional and practical support of the child (HSRC, SYR, 2005; Kaiser Family Foundation, 2006).

Due to their age and stage of development, young people are particularly susceptible to contracting HIV. According to UNAIDS, an estimated number of 5.6 million people in South Africa were infected with HIV by 2009, with a prevalence rate among adults 15-49 years of age of 17.8%. Approximately 1.9 million children and young people, aged 0–7, have been orphaned due to AIDS (UNAIDS, 2011). HIV infection levels differ substantially by age and sex, with a very uneven distribution among the nine provinces ranging from 25.0% in KwaZulu-Natal to 6.2% in Western Cape (UNAIDS, 2011). Inter-district HIV prevalence variation in the country for pregnant women is between 0% and 46%.

For women, and especially young women, the risk of contracting HIV does not only lie in their greater biological vulnerability to infection, but also from gender roles and power disparities that limit their ability to follow the usual prevention 'ABC'-prevention steps. The HIV risk in young women, and in particular young black women-the group at highest risk of acquiring HIV infection in Southern Africa–is driven by three interlinking factors: 1) no sense of the future or control of their destiny, which is exacerbated in settings where gender-based violence is epidemic, such as in South Africa; 2) poor personalization of HIV risk; and 3) lack of knowledge of HIV status (Abdool Karim Q., Humphries, H., 2011).

Another common risky behavior among young people is the use of tobacco-, alcohol- and substance: 21% of young people in grades 8–11 said that they are currently smoking, while 29% indicated that they were involved in binge drinking in the past month, and 10% indicated that they have used dagga in the past month (MRC, 2010). Furthermore, 7% said they had ever used mandrax; 7% said they had ever used cocaine and 6% said they had ever used heroine (MRC, 2010).

South Africa is known for its high levels of violence and crime. This is also reflected in the behavior of many young people as more than one third (36%) of learners in grades 8–11 indicated that they had been bullied, 31% had been involved in a physical fight, 19% had been a member of a gang while 8% carried a weapon and 16% a knife in order to protect themselves (MRC, 2010). Research has indicated that in addition to being disproportionately victims of crime and violence, young people are also over-represented as perpetuators of crime. For example, in June 2002, 36% of the prison population was under the age of 16 years, while 53% of those awaiting trial fell into the same age group (HSRC, 2005).

Young people (grades 8–11) also reported having feelings of sadness and hopelessness (20%), with the same percentage having considered committing suicide (MRC, 2010). The highest rates of suicide in South Africa occur in the 20 to 34 year age range and more than 10 000 young people (age 18–35 years) kill themselves every year (HSRC, 2005).

From research it is clear that many young South Africans live in low-income environments which pose ample opportunities for risky behavior. A poverty line of R800 per month per household is regarded as an ultra-poverty line and is used to denote an 'indigent' household. More than half of South Africa's children or 55% were living under these circumstances in 2005. In 2005 almost two-thirds (63%) of African children lived in ultra-poor households, compared to 24% colored children, 15% of Indian children and 4% of white children (Leatt, 2006). Urban-rural location also plays a key role in the distribution of poverty, with the majority of poor people living in rural areas. The concentration of poverty in rural areas is also crucial to the distribution of poverty among the provinces (HSRC, 2005).

Statistics South Africa (STATSSA) reported an official unemployment rate of 25% in 2006. The General Household Survey 2005 indicated that 59% of children had an employed adult (parent or someone else) living with them. However, the likelihood of a child living with an employed adult varies across the different provinces with children living in Limpopo, Eastern Cape and North West Province being least likely to live with an employed adult (Leatt, 2006).

Research has indicated that the percentage of children accessing all types of social grants has increased tremendously from 15% in 2002 to more than 52% by 2009. This figure is indicative of the large proportion of needy children in society as well as the improved coverage of eligible children (STATSSA, 2010).

According to Statistics South Africa attendance of educational institutions is higher than 90% for 14-16 year olds, but it drops sharply to 70% by age 18 years. Furthermore, a large

proportion of children fail to pass Grade 7 by the age of 15 years and the proportion of 17 year olds yet to pass Grade 9 is even larger. By age 23, only 13% of adolescents are attending educational institutions and 30% are unemployed. An estimated 3.3 million adolescents aged 15 to 24 years are not attending education institutions and have not completed their secondary education. The reason cited by 36% of them for not continuing their education is a lack of money. Only 10% said it was due to poor academic performance (STATSSA, 2010).

HIV and Young People in South Africa

HIV is most commonly transmitted through heterosexual sex. South Africa, with a population of 48.5 million, has a highly generalized AIDS epidemic. UNAIDS (2008) estimates HIV prevalence among adults aged 15-49 at 18%. The HIV epidemic particularly affects South Africa's adolescents, aged 15–24, and in particular young women. According to the 2008 UNAIDS report 13% of young women are living with HIV compared with 4% of young men living with HIV. Major causes of HIV infection among young people include early sexual debut, multiple sexual partners, unprotected sexual intercourse, and age mixing.

Statistics

- Between 10-13% of young people start having sex before age 15 (HSRC, 2009; Harrison et al. 2005; MRC, 2010).
- Almost 2 times more males than females are sexually active before age 15 (HSRC 2008, in HSRC, 2009).
- Among adolescents (15–24 year olds) who reported ever having had sex (67%), the mean age of first sex for males was 16.4 years and 17 years for females (RHRU, 2003).
- From 2005 to 2008 there was a substantive increase in the percentage of teenagers who had an older sex partner (from 10% to 15%). The same pattern was also found among females and the percentage increased substantively from 19% in 2005 to 28% in 2008 (HSRC, 2009).

The percentage of adolescents aged 15-24 years who reported multiple sexual partnerships did not change significantly between 2002 (16%) and 2008 (18%). However, in 2008 five times more males (31%) reported having had more than one sexual partner in the past 12 months than females (6%). (HSRC, 2009). A similar trend was observed amongst males and females 15 years and older where in 2008 five times more males (16%) reported having more than one sexual partner in the past 12 months than their female counterparts (3%). (HSRC, 2009).

Alcohol use among South African sexually active adolescents is high. Of all the sexually active learners in grades 8-11, more than 16% reported using alcohol before having sex, with more boys (20%) than girls (12%) using alcohol before having sex. In addition, nearly 15% used drugs before sex with no variation between males and females (MRC, 2010). Furthermore, 29% of young people in grades 8–11 said that they were involved in binge drinking in the past month, with 10% indicating that they have used dagga in the past month (MRC, 2010).

Of the 38% grade 8–11 learners who indicated that they ever have had sex, 41% said they had two or more partners in their lifetime and 52% said they have had more than one partner in the past 3 months (MRC, 2010).

Early Age of Sexual Initiation

Early sexual initiation is when a girl or boy has sex before the age of 15 years, and although fewer than 10% of young people in South Africa start having sex before the age of 15 years, it is still an issue of concern. Having sex at an early age has major implications for contracting HIV and STI. Studies show that girls or boys having early sex are more likely get HIV or STIs because they are also more likely to:

- have more frequent sexual intercourse,
- use condoms less frequently and consistently, and
- have more sexual partners (Donenberg et al. 2003, in HSRC, 2009).

Typically, young people start having sex at an early age because of:

- experimentation with alcohol and drugs, which often leads to experimentation with sex;
- peer pressure from mixing with older adolescents who have already had sex;
- peer pressure to 'fit' in with peers who are sexually active (HSRC, 2009); and
- pressure from older men who target young girls for sex, especially those who are virgins (HSRC, 2008 in HSRC, 2009).

Early sexual debut is also linked to adolescents being less likely to use contraceptives and often results in unplanned pregnancies (Baumgartner et al. 2009 in HSRC, 2009). Evidence-based studies suggest that girls who are sexually abused are more likely to engage in riskier sexual behaviors compared to their peers (HSRC, 2009).

Multiple Sexual Partners

The practice of people having more than one sexual partner at the same time substantially increases the chances of HIV infection because of widening web of sexual networks. When groups of people are linked in a sexual network, a new infection has the potential to move rapidly between people: because newly infected people often do not know their status, and have a high viral load, an uninfected person is almost ten times more likely to be infected than someone engaging in less risky sexual behaviors (HSRC, 2009).

Multiple sexual partnerships often include intergenerational relationships, which are motivated by financial benefits. This usually takes place between younger girls, and older males who provide monetary or other gifts. Such relationships are sometimes also condoned by family members who may benefit from the material proceeds of such relationships (HSRC, 2008 in HSRC, 2009). Other reasons for having multiple sexual partners include sexual exploration, peer pressure, acquisition of status as a product of being sexually desirable, seeking sexual pleasure, and de-emphasis on long-term relationships (HSRC, 2008 in HSRC, 2009).

Intergenerational Sex
Intergenerational sex is another high-risk behavior that drives the HIV epidemic in South Africa. Intergenerational sex, also known as age mixing, is when young women or girls get into sexual relationships with older men or "sugar daddies". There is increasing evidence of sex between young girls and older men from other South African studies (Leclerc-Madlala 2008 and Pettifor et al. 2004 in HSRC, 2009). These relationships are often transactional, where money or other gifts are attached to sexual favors, and poverty remains a motivator for young girls seeking older partners (HSRC, 2009). Adolescents who have partners five or more years older are naturally exposed to HIV through interaction with older men, who fall into a higher prevalence age group.

Research also indicates that partners of pregnant teenagers are significantly older, less likely to be in school, and more likely to have other girlfriends (Jewkes et al. 2001 in HSRC, 2009).

Sexually Transmitted Infections (STIs)
The presence of an STI greatly increases a person's likelihood of acquiring or transmitting HIV. Of the 38% grade 8 – 11 learners who said they had ever had sex, 4% indicated that they ever had an STI and of those that had an STI, only 55% said they received treatment (MRC, 2010).

Substance Use
Alcohol and drug use are commonly found among young people experimenting with sex, and use of these substances often lead to impaired judgment and decision-making, which, in turn, leads to risky sexual behavior, and the consequences: HIV infection, sexually transmitted infections (STIs) and unwanted and early pregnancies (Kalichman et al. 2008 and Wechsberg et al. 2008 in HSRC, 2009).

Lack of Awareness
Research has shown that adolescents have insufficient knowledge about the transmission of HIV. Furthermore, between 2005 and 2008, there was a significant decrease in accurate knowledge about the sexual transmission of HIV and the rejection of major misconceptions of HIV transmission among young people. In 2008 only 27.0% of females and 30.4% of males aged 15–24 years could provide the correct answers to a set of questions regarding the transmission of HIV and myths about HIV and AIDS as opposed to 44.7% males and 44.9% females in 2005 (HSRC, 2009). According to the YRBS 2008, 21.5% of learners in grades 8–11 ever had an HIV test (MRC, 2010).

Adolescents need accurate, age-appropriate information about HIV infection and AIDS, including how to talk to their parents or other trusted adults about it, how to reduce or eliminate risk factors, how to talk to a potential partner about risk factors, where to get tested for HIV, and how to use a condom correctly. Information should also include the concept that abstinence is the only 100% effective way to avoid infection.

Coming of Age of HIV-Positive Children
Many young people who contracted HIV through perinatal transmission are facing decisions about becoming sexually active. They will require ongoing counseling and prevention education to ensure that they do not transmit HIV.

Adapting Project AIM for South Africa

The *Project AIM* curriculum provides a framework in which adolescents consider their hopes, possibilities and goals. Adolescents, themselves, provide the bulk of this content therefore the work of adaptation was primarily minor surface adaptations to account for differences in language and cultural context. CDC South Africa Adolescents Prevention staff partnered with the co-developers of Project AIM to complete surface adaptations for language and cultural references to make it relevant for South African adolescents.

A career exploration activity was created to replace a similar activity in the US-based program. The adapted curriculum was then field tested in two community-based settings by CDC South Africa staff in partnership with Hope Education. Field-testing indicated that, with minor additional adaptations to adjust language and instructions, the Project AIM curriculum is acceptable for use with South African adolescents ages 11-14 in both rural and peri-rural, low-income areas.

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Project AIM's Alignment with National Curriculum Statement, Life Orientation, Grades 7—9

Project AIM activities cover concepts and skills of the **National Curriculum Statement (NCS) for Life Orientation in Grades 7—9.** The NCS are written expectations for what learners should know and be able to do by grades 7—9 to promote development of self in society, social and environmental responsibility and orientate them to the world of work. The standards provide a framework for curriculum development and selection, instruction, and learner assessment in the learning area Life Orientation.

National Curriculum Statements	**S1**	**S2**	**S3**	**S4**	**S5**	**S6**	**S7**	**S8**	**S9**	**S10**	**S11**	**S12**
Development of self in society (Gr 7)												
Concept: Self-image Personal strengths & weaknesses Personal interests & abilities Strategies to enhance self-image (respect for self) Strategies to enhance others' self-image (respect for others)	X	X		X	X	X	X	X		X		X
Concept: Peer pressure Different forms of peer pressure Effects of peer pressure: unhealthy sexual behaviour, bullying, etc. Appropriate response to peer pressure – assertiveness skills Negotiation skills: ability to disagree in constructive ways Where to find help		X		X					X			
Development of self in society (Gr 8)												
Concept: Self-concept formation and motivation Factors that influence the above (media, friends, peers, family, culture, religion, environment, community, etc.) Positive self-talk • Individuality & uniqueness • Personal achievements	X	X		X		X	X	X		X		X
Development of self in society (Gr 9)												
Concept: Goal-setting skills: personal lifestyle choices - Influence of media, environment, friends and peers, family, culture, religion and community on personal lifestyle choices - Appropriate responses to influences on personal lifestyle choices: - Informed decision-making skills – choice between good and bad influences - Assertiveness skills – acting with confidence and firmly on the right decision	X			X		X	X	X	X	X	X	X

National Curriculum Statements	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
World of Work (Gr 8)												
Different learning styles			X									
Six career categories: investigative, enterprising, realistic, artistic and conventional - Interests and abilities related to each career category - Thinking and learning skills required by each career category - School subjects related to each career category			X		X	X	X	X				
Relationship between performance in school subjects and interests and abilities: - Types of learning activities related to different subjects: practical, theoretical, individual or group activities - Demands of each subject: thinking and learning skills required			X					X				X
Decision-making process: - Steps in choosing career category relating to individual strength, ability, interest and passion			X				X	X		X	X	
World of Work (Gr 9)												
Time-management skills: accountability in carrying out responsibilities -Reading and writing for different purposes: -Keeping a journal; summarising and improving reading and writing skills			X					X				
Career and subject choices: - NCS subjects in Grades 10, 11 and 12 - Careers related to different subjects - Qualities relating to different careers and subjects: strengths and weaknesses; interests and abilities - Decision-making skills: steps in choosing subjects relating to: one's interests and abilities one's career of interest			X		X		X	X				X
Study and career funding providers -Plan for own lifelong learning: -Goal-setting for lifelong learning			X								X	

Reporting Child Abuse and Sexual Abuse of Minors

The Constitution 1996, Section 28 of the Bill of Rights, affirms children's rights to protection from maltreatment, neglect, abuse or degradation, and to be protected from exploitive labour practices. Three pieces of recent legislative reform, namely the Children's Act, the Sexual Offenses Act, and the newly adopted Child Justice Act, give effect to these rights in a comprehensive manner.

Children's Act 2005, Act 38 of 2005 deals with child protection and the child protection system especially Chapter 7.

Sexual Offences and Related Matters Amendment Act 2007, Act 32 of 2007 deals with sexual offences while Chapter 3 specifically deals with sexual offences against children.

Child Justice Act 75 of 2008, creates a new procedural framework for dealing with children who come into conflict with the law. Child abuse or neglect is not often reported because the child does not know where to go or who to trust. So, who is there to help the children?"

According to the Children's Act, professional people, including any teacher, medical practitioner, psychologist, dentist, registered nurse, physiotherapist, speech therapist, occupational therapist, traditional health practitioner, legal practitioner, social worker, social service professional, minister of religion, religious leader, member of staff at a partial care facility, shelter, drop-in centre or child and adolescents care centre, labour inspector or police official, *must* report a possible case of child abuse the provincial department of social development, a designated child protection organisation, police official or clerk of the children's court. The Act also says if anyone else thinks that a child is being abused, they *may* report the abuse to a police official or a social worker or to a designated organization.

There are different categories of abuse:

- **Physical abuse**: Could be bruises, scars, fractures, burns, bites, abdominal or head injury or injury to internal organs; strangulation or suffocation; poisoning, any repeated injury for which explanation is inadequate or inconsistent, etc.
- **Sexual abuse:** Sexually molesting or assaulting a child (any person younger than 18 years) or allowing a child to be sexually molested or assaulted; encouraging, inducing or forcing a child to be used for sexual gratification of another person; participating or assisting in the commercial sexual exploitation of a child; incest with a child.
- **Emotional abuse:** It may take the form of failure to meet a child's need for affection, attention, stimulation, or constant verbal abuse, rejection, isolation, oppression; threats of violence or attempts to frighten the child; exposure to family violence; corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities and exposure to the negative impact of the mental or emotional condition of the parent /caregiver or anyone living in the same residence as the child or young person.
- **Deliberate neglect:** Continuous failure to protect a child from exposure to any danger, cold, starvation, substance abuse, failure to provide the necessities required

to sustain the life of the child or young person; failure to provide appropriate adult supervision of the child or young person leading to an increased risk of harm; failure to seek, obtain or follow through with medical care for the child or young person, resulting in their impaired functioning or development; abandoning a child or young person without arranging necessary care for them and with no intention of returning; failure to provide for the child's educational needs, such as schooling, support and stimulation.

Reporting Cases of Abuse or Neglect

If a report of abuse has been made to a professional person, this person must make sure the child is safe and then tell the Department of Social Development or a designated organization, like Child Welfare, within 24 hours. After the report has been made, a social worker must make sure that the information in the report is truthful and the child is safe or make sure that the child's life at home improves.

Note: Professional people have to report the information on Form 22 which is obtainable from any Department of Social Development office or www.dsd.gov.za

The person who makes a report in good faith is not liable to civil action on the basis of the report. The identity of the reporting person will be treated as confidential. The following information is important:

- The name and surname of the child
- Identifying particulars of the biological parents / care-givers.
- Address of where the child currently lives and, if away from parents, the address of the parents.
- Dates and type of incidents.
- Details of circumstances giving rise to the abuse.
- Any contact details of other persons who could confirm the alleged abuse.
- Your contact details on the file, should the designated social worker have to follow-up certain details with you, is important.

When reporting a case, children are not always removed from the family. This is only done when the child's life is in danger. The principle of keeping a child within his or her family as long as possible is valued. In any decision, ensuring the best interests of the child would be paramount.

USEFUL CONTACT NUMBERS

Childline 080 005 5555
Child Welfare South Africa 011 492 2884
South African Police Service emergency number 10111
Crime Stop 086 001 0111
Human Rights Commission 011 484 8300
Department of Labour (Pretoria Head Office) 012 320 2059
Street Law (National Office) 031 260 1291

Provincial Departments of Social Development:
Gauteng 011 355 7843/7823
KwaZulu-Natal 033 264 2068
Northern Cape 053 874 9100
Western Cape 021 483 4153
North West 018 388 2021
Limpopo 015 293 6000/6331
Mpumalanga 013 766 3156/3120
Free State 051 409 0590
Eastern Cape 040 609 5303/4/5 or 608

Section III:
Requirements for Successful Implementation

Project AIM Time Requirements

Facilitators will need time to complete a training course, and become certified to deliver *Project AIM.* The Program Manager will attend Program Manager Training.

For each participant group receiving *Project AIM* during a 6 week period, estimated intervention delivery time per week includes:

- 2 to 3 hours to deliver 2 sessions of *Project AIM* per week (6-week period)
- 30 minutes to set up before the session and 30 minutes to clean-up after each session
- 1 hour for facilitators (and occasionally additional staff) to brief and debrief in preparation for *Project AIM* session
- 1-2 hours to complete additional tasks between sessions

Project AIM Staffing Requirements

The number and type of staff working on *Project AIM* will be dependent upon the scope of the project and the number of groups being run simultaneously. At minimum, the following personnel are recommended:

- **Project Manager**: Coordinates all activities of *Project AIM* from project planning, implementation, and monitoring.
- **Trained and certified Facilitators:** Co-facilitate *Project AIM* and may assist in recruiting participants.
- **Monitoring and Evaluation Coordinator:** Performs site visits to observe program delivery and monitor fidelity. They also monitor, collect, summarize and ensure timely submission of reports.

Project Manager
The following list of items below contains some of the Project Manager's primary responsibilities. They are not necessarily the only tasks that the program manager will do during in the course of the intervention.

PROJECT MANAGER DUTIES	
✦ Managing the budget	✦ Recruiting participants
✦ Conducting quality assurance	✦ Hiring and managing intervention team
✦ Monitoring fidelity	✦ Establishing and overseeing the evaluation plan
✦ Recruiting and selecting the advisory board	✦ Overseeing the intervention
✦ Overseeing the advisory board	✦ Conducting briefing and debriefing sessions
✦ Preparing the intervention materials	✦Makes referrals to other organizations

Facilitators
Project AIM requires two facilitators. Facilitators are a very important aspect of successful Project AIM delivery. They guide adolescents through the *Project AIM* journey. Facilitators should possess the following qualifications:

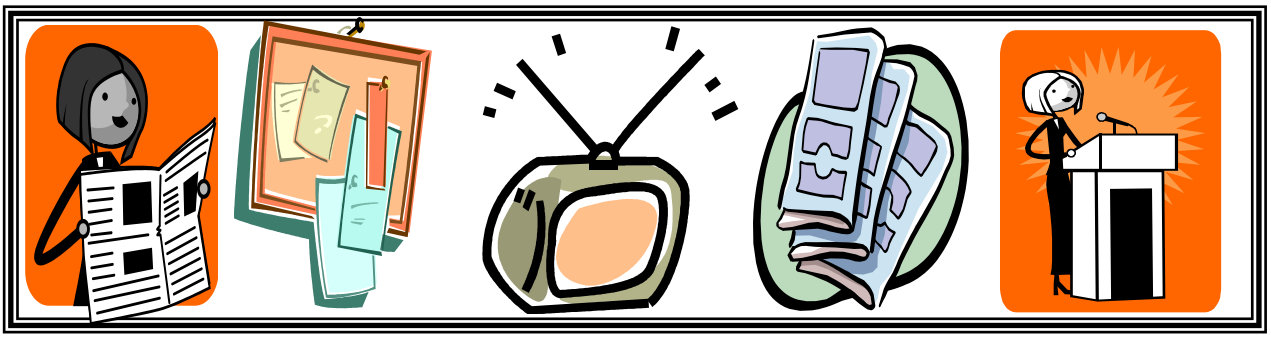
- Passed grade 12
- Post grade 12 qualifications e.g. diploma or certificate
- Experience working with adolescents in and out of schools
- Good group facilitation skills
- Ability to relate to, inspire, interact and connect positively with adolescents
- Possess good group management attributes
- Willingness to work long hours
- Must be able to attend Project AIM facilitators' training.

The following list of items contains some of the Facilitator's primary responsibilities. They are not necessarily the only tasks that Facilitators will undertake in the course of the intervention.

FACILITATOR DUTIES	
✦Attend the training course for *Project AIM* and become certified	✦Organize intervention materials
✦Conduct meetings to inform parents and community about *Project AIM*	✦Recruit participants
✦Co-facilitate all sessions of *Project AIM* for each cycle	✦Complete out of session tasks
✦Debrief with Project Manager and co-facilitator	✦Complete process and outcome evaluations

If a facilitator leaves during the middle of a Project AIM cycle, contact your CDC liaison. Additional trainees who may be present at training and certified but not hired may serve as replacements. Depending on the timing, an additional training may be scheduled to make sure your organization has enough facilitators at all times.

If the facilitator leaves during the middle of an AIM cycle and it is not possible for a replacement facilitator to be trained and certified prior to assisting, Program Managers and existing facilitators can train the replacement to serve as an assistant to help out in other ways until s/he is properly trained. S/he could assist with completing the out of session tasks (business cards, letters of recommendation, etc.), conducting individual interviews, or assisting adolescents who needs help with the activities. Please contact your CDC liaison before training and engaging an assistant facilitator.



Monitoring and Evaluation Coordinator
The following list of items below contains some of the Monitoring and Evaluation Coordinator primary responsibilities. They are not necessarily the only tasks that the Monitoring and Evaluation Coordinator will do during in the course of the intervention.

MONITORING AND EVALUATION COORDIANTOR DUTIES	
✦ Collects and maintains process and outcome evaluation forms	✦ Submit evaluation reports in a timely manner
✦ Reviews monitoring and evaluation forms for completeness	✦ Periodically debriefs with Project Manager
✦Maintain proper confidentiality at all times, including proper management and storage of completed surveys and all other documents	✦ Communicate effectively with Facilitators to ensure proper completion on Monitoring and Evaluation tasks

Equipment
Facilitators will need access to a computer and a printer with the ability to print materials from a CD disk or downloadable website. Email access may be helpful for communicating with guest speakers.

Location, Room Logistics and Time
Project AIM is designed to take place either in or near the community of the target population. Here are some suggestions for selecting a location and room logistics:

- Adolescent-friendly space
- Flexible seating and table arrangements
- Venues where adolescents currently congregate (e.g., recreation centers, after-school programs)
- Central location - along major transit routes so participants can easily get to the location
- Room needs to be big enough to accommodate 2 facilitators and seat 10-18 adolescents comfortably that allows for group discussion as well as individual and group activities.

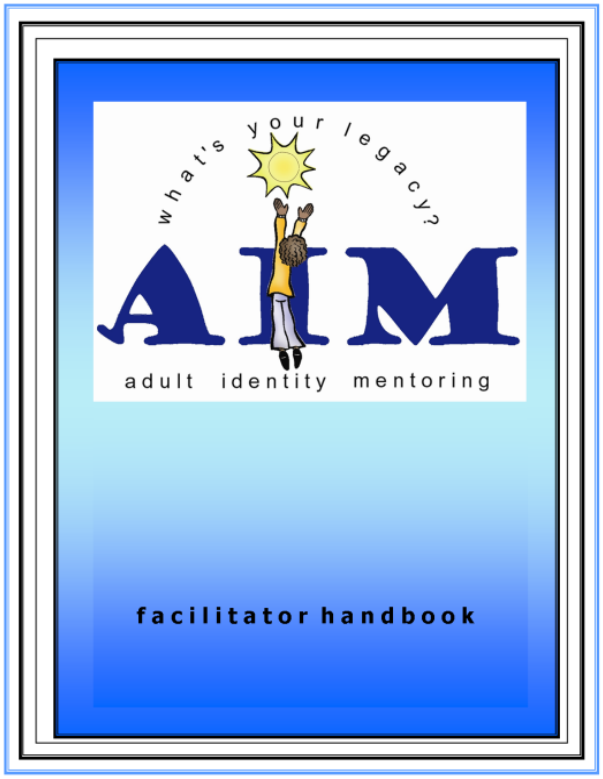
Intervention Materials

Most materials needed to implement the intervention are in the *Project AIM* intervention package and on the *Project AIM* CD-ROM. These materials are:

- *Facilitator Handbook* (Curriculum)
- *Implementation and Monitoring and Evaluation Guide*
- Posters
- Adolescents Workbook
- *Project AIM* Stationary
- *Self-Confidence* cards
- *Role-Play Scenario* cards
- *Communication Style* cards
- *Directory of Images*
- *Career Puzzle Pieces*
- *Positive and Negative* sheets

Facilitator Handbook

As part of the intervention package, the *Facilitator Handbook* will help you deliver *Project AIM*'s sessions. The *Facilitator Handbook* is divided into four PARTS (I, II, III, and IV). Each of the sessions has a cover page with sections on Facilitators and Adolescents Materials, Pre-session Preparation, and Post-Session Tasks. At the end of each session, if appropriate, are How-To instructions for Post-Session tasks.



Additional Intervention Materials

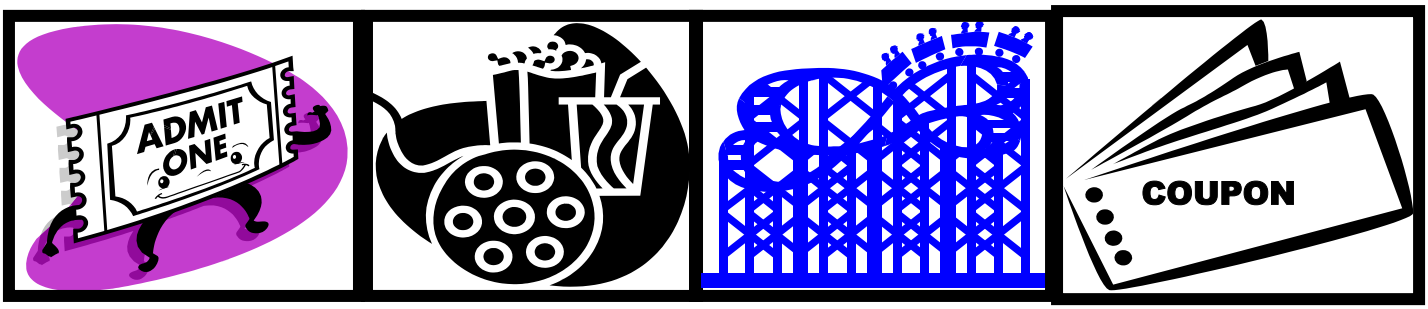
The following items are important to reinforce the core elements of *Project AIM* but are not included in the package. Organizations will need to purchase these items:

- Flip charts with newsprint pads
- Easels
- Markers (non-permanent)
- Envelopes
- Pens
- Calculators for student use
- White/colored paper
- Certificate paper
- Business card stock
- Carabineers
- Portfolios
- Plastic pockets
- Personal computer
- Color printer
- Laminating machine

Incentives and Refreshments

Project AIM is a new and exciting experience for many adolescents; most want to attend and do not need incentives beyond the carabineer key chain and portfolio that are provided as part of the curriculum. If your organization wishes to provide further incentives, please discuss with the CDC program advisors responsible for overseeing *Project AIM* implementation.

Providing refreshments is a nice reward for adolescents who attend, but is not required.



Sample Cost Sheet

The following cost sheet provides an organization with a general cost analysis of expenditures associated with implementing *Project AIM*. This cost sheet makes assumptions based on the number of participants and the amount of staff time for the facilitators. Your amount will vary depending on the organization's location, infrastructure capacity and access to resources:

CATEGORIES		
Staff (based on 1 year of implementation)	**Salary**	**Total Cost**
Project Manager (1 @ 10% FTE)	Annual salary	**Total Cost**
Facilitator (2 per site)	Annual salary x 2	**Total Cost**
Monitoring and Evaluation Coordinator	Annual salary	**Total Cost**
	Total Cost of Staff	**TOTAL COST**
Intervention Materials	**Cost/Unit**	**Total Cost**
Printed posters *(color only)*	1 set (5 posters) per facilitator pair	**Total Cost**
Prestik	1 slab per facilitator	**Total Cost**
Colored pencils	1 package per 4-6 participants	**Total Cost**
Workbook (cost incurred by organization to print out 17 worksheets) *Copies (color only)*	17 printed pages per participant	**Total Cost**
Portfolio	1 per participant	**Total Cost**
Card Stock (10 business cards per adolescents)	1 sheet per participant	**Total Cost**
Self-Confidence Card (6 cards per printed page)	1 card per participant	**Total Cost**
Project AIM Stationary (Thank You Letter, Booster Letter) *Copies (black and white or color)*	2 sheets per participant	**Total Cost**
Key chain	1 per participant	**Total Cost**
Certificate Paper	1 sheet per participant	**Total Cost**
	Total Cost of Intervention Materials	**TOTAL COST**

CATEGORIES		
Basic Office Supplies	**Cost/Unit**	**Total Cost**
Flip chart with Pad	1 flip chart pad per cycle	**Total Cost**
Easel	1 per facilitator pair	**Total Cost**
Markers (Non-permanent)	1 package per facilitator	**Total Cost**
Envelopes sized 22 x 28 cm (to collect Thank-You Letters)	1 per Guest Speaker	**Total Cost**
Envelopes (11x22cm) (to mail booster letters to participants)	1 per participant	**Total Cost**
Pens for adolescents use during each session	Cost of Pens x # of adolescents	**Total Cost**
1 Calculator per groups of 4-6 adolescents	Insert cost of Calculators	**Total Cost**
Postage for mailing of Booster Letter	1 letter per participant	**Total Cost**
Glue sticks	1 per 2-3 participants	**Total Cost**
Scissors		
Cleaning material (to wipe pen marks from posters)		
	Total Cost of Basic Office Supplies	**TOTAL COST**
Optional Expenses	**Cost/Unit**	**Total Cost**
Snacks/Refreshments	(Insert cost) per session	(Insert cost) per session x 12 sessions
Other expenses	**(Insert cost)**	**(Insert cost)**
	Total Cost of Optional Expenses	**TOTAL COST**
Travel	**Cost/Unit**	**Total Cost**
Kilometer/Miles to/from intervention location (if other than regular work place)	# kilometer/miles X cents/kilometers/mile	# kilometer/miles X cents/kilometers/mile
	Total	**TOTAL COST**
	GRAND TOTAL	**TOTAL COST**

Section IV:
Getting Started with Implementation

Marketing for Project AIM

The final step in preparing for implementation is marketing *Project AIM* to your community. The advisory board is another useful marketing tool because the members can advise your organization where to place the marketing information sheets. Also, they can identify other ways to engage the community. Organizations want to concentrate their outreach and recruitment efforts where there are substantial numbers of at-risk adolescents between the ages of 11-14. Collaborating and forming partnerships with other organizations such as FBOs, NGOs, Department of Sports and Recreation, after-school programs, tutoring programs, social service organizations, and local primary/secondary schools are effective in marketing *Project AIM* to a broad group of adolescents in the community.

Organizations also can send fliers, press releases, and public service announcements to local religious organizations, radio and TV stations, or post advertisements in local papers. Another recommendation is to attend community-wide events/meetings relevant to adolescents and their families to publicize *Project AIM*.

Community Advisory Board

The Community Advisory Board is a small group of individuals made up of community leaders, service providers, parents, and adolescents from the target population. The advisory board can be helpful in adapting *Project AIM* to the unique needs of adolescents in your community. Your organization can pilot the intervention sessions with the board, and the members' feedback can help your organization improve the quality of delivery. Some other ways that the advisory board can assist your organization are by providing ideas about marketing, recruiting, and retention. The advisory board is a valuable resource in making *Project AIM* a culturally appropriate intervention for your community. The size and membership of the board will vary according to your organization's need and may change during the course of the project. The advisory board has people from the community who understand the various needs of the adolescents and know the best way to effectively communicate with them. Adolescents may be an important part of your advisory board.

Training and Certification of Facilitators

All facilitators must go through formal training and certification for *Project AIM*. Formal training is designed to familiarize facilitators with the goals, purpose, and specific details of *Project AIM*. The *Project AIM* training will enhance specific knowledge and skills needed to deliver the program.

During training, facilitators will learn the content of the *Facilitator Handbook*. Training will also emphasize the theory and core elements of *Project AIM*. During the training, participants will experience all the activities in *Project AIM*. The participants will demonstrate facilitation of some of the activities themselves. Demonstrations are also used by trainers to assess a trainee's ability to deliver the content correctly and appropriately. This hands-on approach is the first step in ensuring that facilitators are implementing *Project AIM* successfully.

After participants attend the formal *Project AIM* training, they will have the opportunity to become certified. Only those trainees who demonstrate a comprehensive understanding of the *Project AIM* curriculum and the ability to adequately deliver the sessions will be certified as *Project AIM* facilitators. Trainees who are not certified can be retained as back-up facilitators and may be called on later in the *Project AIM* cycle should there be a need. Those who are certified as *Project AIM* facilitators will still need to practice the intervention activities before implementing with adolescents. One of the goals of the practice session is to give the facilitators an opportunity to spend time learning the intervention before implementing with adolescents. A great way for facilitators to practice is to hold practice sessions.

Participants for these practice sessions can be recruited from the staff or organization volunteers. But, if volunteers participate, it is important to make sure they understand their role and the goals of the practice sessions. Before each session, the facilitators should decide who will lead each activity. These roles may be adjusted between practices.

The practice sessions will provide an opportunity to manage behavior and conflicts. The sessions will increase facilitators' comfort-level with the intervention process and promote flexibility in adjusting to the needs of the participants. In addition, the practice session will help facilitators assess their facilitation skills. Project managers and staff members may want to observe the practice sessions and give facilitators feedback. The project manager may choose to use the *Project AIM* Fidelity Observation Form found in the *Section V: Monitoring and Evaluation of Project AIM* to evaluate the practice session.

Once implementation with adolescents begins, the project manager may want to have a plan in place to ensure quality of delivery. Quality assurance is discussed in detail in the maintenance section of this document.

Recruitment and Retention of Adolescents

Your organization should have a recruitment plan in place that details how participants will be recruited, recruitment venues, recruitment/marketing tools, and number of participants to be recruited. Implementing organizations may use the *Project AIM Recruitment Forms* (Appendix A). The advisory board and organization staff can provide your organization with the answers to some recruiting questions, such as:

- Describe the recruitment/outreach methods that your organization is currently using to (a) promote your programs and services and (b) encourage adolescent participation.
- Where is the best place to recruit at-risk adolescents in your community who are between the ages of 11- 14?
- What other adolescent-serving organizations will your organization partner with to help in your recruitment efforts?
- What might motivate adolescents to attend *Project AIM*?
- What strategies will your organization use to retain adolescents in *Project AIM*?

The optimal group size is between 10-18 adolescents. Because much of the learning occurs during adolescents' discussions it is important that you have a large enough group to facilitate a discussion but small enough so all members are able to participate. For groups with more than 15, it is recommended to have an assistant work with the facilitators to help with the out of session tasks and other logistical or administrative issues.

If your organization does not have enough adolescents within its programs or services to participate in *Project AIM*, a well-developed recruitment plan should clearly identify a variety of strategies to recruit (e.g., word of mouth, letters to parents and teachers, program orientation, advertisement) and locations from which to recruit (e.g., schools, after school programs, faith-based organizations).

Some organizations that implemented *Project AIM* have recruited adolescents with their friends and relatives to participate in the same group sessions. Their inclusion in the same group sessions did not negatively impact their participation in *Project AIM*. However, organizations must proceed with caution and set appropriate guidelines/boundaries in situations where family members or parents are the facilitators delivering the same group sessions which include their child(ren). This intervention is not designed to be delivered by parents to their adolescents.

People who are not participants in the intervention are not allowed to attend the session unless they are conducting observations and have the permission of the facilitators and adolescents in advance. This is to honor the group agreements of respecting the privacy and confidentiality agreed upon by the adolescents during the first session.

Start a wait list for interested adolescents for the next cycle of *Project AIM*. If the dates are confirmed, share the start date with the adolescents and remind him/her to check back with your organization before the start date.

Keeping adolescents engaged in the process can be a difficult task. The facilitators have the responsibility for making sure that adolescents have a chance to contribute to the discussion, to participate in activities, to share their thoughts, and create a safe, supportive, and welcoming environment.

Facilitators should work hard to retain the adolescents. To help in this process, consider having snacks or refreshments available during the sessions. However, this is not a requirement. Selecting a location that is accessible to adolescents and allowing adolescents to feel comfortable can make them more likely to return.

Consent and Ethical Issues

Parent/Guardian Permission
See Appendix B for an example of a parent/guardian permission form that your organization can use for consenting adolescents under the age of 18 to participate in Project AIM. Your organization may modify this form; however it is important to include information about Project AIM, date and time of the sessions, location where Project AIM will be conducted, the approximate start date and length of the program, and other organization expectations for the parents and adolescents.

Planning for Legal and Ethical Issues
One crucial step in preparing for the intervention is setting up the proper policies and procedures that will protect the organization, the *Project AIM* intervention team, and the participants. Organizations need to train their staff on the laws regarding the reporting of child abuse and sexual abuse of minors. See Section II for more information in this regard.

Involving Parents in Project AIM

There are many ways in which parents or other adults can become involved in *Project AIM* for adolescents. Throughout the intervention, adolescents are encouraged to communicate and reach out to adults in their lives about their experiences in *Project AIM*. At the end of each session, there are *to-do tasks* that facilitators ask adolescents to complete. For example, facilitators at the end of Session 1 ask adolescents to have a conversation with their parents or other adults about legacies and who they think have left a legacy. Adolescents are to share their conversations at the next session. There will be several opportunities for parents to become involved in this manner as a way to reinforce *Project AIM* core elements. It may also be helpful to have an introductory meeting for parents prior to the start of *Project AIM*. Parents can be given basic information about *Project AIM* and be allowed to ask questions.

There may be parents/guardians who are appropriate to participate as guest speakers during that session of *Project AIM*.

Attendance Policy

Implementing organizations should have an attendance policy in place. Organizations may use the Project AIM Participant Information Form provided in Section V to help track attendance. The policy should clearly explain the organization's expectations that adolescents attend the sessions.

All new members of *Project AIM* must attend Session 1 unless a reasonable exception, such as unexpected, illness is made. If the exception is made, the adolescent must attend Session 2 to be registered for that project cycle. *Project AIM* is closed to new members after Session 1. If your organization knows when the next cycle of Project AIM will begin, a waiting list should be started for adolescents that want to participate in the future.

The attendance policy should also address tardiness based on the organization's general rules or by incorporating it in the group agreement between the adolescents and the facilitators during Session 1. Each session builds on the previous session, so missing sessions undermines the ability of the adolescents to fully participate in the intervention.

Adolescents should strongly be encouraged not to miss Sessions 5 and 6. Should a participant miss Session 5, the facilitator should ensure that he/she spends 5 – 10 minutes with the adolescents before Session 6 explaining how to complete the *Career Rainbow.* The adolescents have to complete the worksheets and the facilitator has to produce a personalized career report before the session starts as it is an integral part of Session 6.

Given the importance of group interaction, it is not recommended to make up other sessions with adolescents individually. If a large number of adolescents miss a session for an acceptable reason, such as a weather event, facilitators may consider delivering a special make-up session where they entire session in repeated in full.

If adolescents miss other sessions (besides 5 and 6), it is okay if they do not make up these sessions as most of these activities are meant to be done in groups within the context of the other adolescents. If you have a large number of adolescents who miss sessions, you may consider having special make-up sessions where the entire session is repeated for adolescents who have missed it.

If an adolescent misses 3 or more of Sessions 1-11 of *Project AIM*, they will not receive a certificate and portfolio during the Graduation Ceremony in Session 12. Although adolescents are required to complete the activities for Session 5 and 6 if they miss the session, this missed session still counts towards their overall total. It is recommended that these adolescents be invited to re-start with the next cycle, and not attend Session 12. If implementing with PEPFAR funds, requirements for attendance are outlined in Appendix C and should be followed.

Briefing

Briefing before sessions is an opportunity for project managers to discuss upcoming *Project AIM* sessions, to check in with facilitators regarding out of session tasks, or to update facilitators on the status of materials, etc. Project managers may wish to combine a briefing and debriefing (more information about debriefing is below) into one meeting with facilitators, or to schedule regular briefings throughout the *Project AIM* cycle. Here are a few topics that may be discussed:

Upcoming Project AIM sessions

- Prepare the schedule for upcoming sessions

Materials

- Check in with facilitators to see if any materials are running low
- Update facilitators on the status of the arrival of materials for future sessions

Out of Session Tasks

- Guest speaker —ensure guest speakers have been invited, confirmed, and thank you letters have been mailed after their visit
- Letters of recommendation—ask for progress update on writing Letters of Recommendation
- Interviews—ask for progress update on interviews, ensure that facilitators will be able to complete all interviews at the appropriate time
- Booster Letters (after the completion of Project AIM)—ensure all participant addresses are collected, booster letters created and mailed

Debriefing

The purpose for the debriefing is to allow the facilitators a time to release emotions from the sessions, to trouble shoot, and to gain support for their efforts as facilitators. The role of the program manager or staff member is to guide the debriefing session. The program manager does not act as a counselor during the debriefing. Instead, the program manager should create an environment where the facilitators can relax and voice their opinions without fear of scrutiny.

Your organization may have some specific methods for debriefing; the following is designed to add to your organization's existing procedures.

How to Conduct Debriefing Session

The following questions can be used that help elicit discussion about thoughts, feelings, and behaviors so that the facilitators can thoroughly express themselves:

1. What is going well? Why?
2. What is not going well? Why?
3. How can we create a positive environment where adolescents feel comfortable participating?
4. What concepts, activities, and/or worksheets did participants have trouble understanding?
5. How could delivery of the upcoming session be improved?
6. Were there enough chairs?
7. Could the participants be overheard?
8. What kinds of strategies did the facilitator use to deal with behavioral problems that came up during the session?
9. Were any activities skipped or altered? Why?

The main goal of debriefing is that the facilitators leave stress behind and feel confident about the next session. This is an opportunity for facilitators and project managers to:

- Ask if there are any questions
- Review evaluation forms and data collection that facilitators will need to do including: feedback from adolescents and tracking participation
- Review maintenance issues. Focus on facilitators' roles in maintenance, rather than administrative responsibilities
- Record keeping
- Creating a library of resources
- Understand who to work with at the organizations to keep *Project AIM* going
- Review financial support issues

Quality Assurance

Quality assurance is an evaluation activity that helps to ensure that organizations are delivering *Project AIM* with *fidelity* – that is with appropriate staff, according to the Implementation and Monitoring and Evaluation Guide, and faithful to the core elements. *Project AIM* has been shown to be an effective program. However, the effectiveness of this program depends on how well staff and facilitators adhere to the goals and abide by the core elements. Your quality assurance activities should ensure that *Project AIM* will produce risk reduction among adolescents.

Variability in style of group facilitation or the dynamics of individual adolescent groups could affect the integrity of the program. Specific strategies can be used to minimize these effects and ensure the fidelity of the program:

- Each *Project AIM* session activity is structured with step-by-step instructions and time parameters. It is important to follow these guidelines and work within the structure of each activity.

- Conduct briefing and debriefing sessions with facilitators before and after the program to assess possible issues with program delivery and their opinions of how the program worked.

Conduct on-going evaluation to:

- Determine whether the program was effective
- Determine whether adaptations of the program content changed the integrity of the program
- Determine accountability for funds and resources
- Improve program operations, thereby allowing sustainability of the program within your organization

As part of overall quality assurance activities, your organization will need to conduct periodic process monitoring and evaluation of the program.

Section V:
Monitoring and Evaluating of Project AIM

Introduction to Monitoring and Evaluation

This section serves as a guide for how to monitor and evaluate your organization's *Project AIM* intervention. Monitoring and evaluation are data collection activities used to assess whether your organization is meeting the program objectives established for *Project AIM*. In particular, these data can provide answers to important questions about *Project AIM*'s planning, implementation, and outcomes.

There are two key reasons for monitoring and evaluating your *Project AIM* intervention – accountability and program improvement. Accountability can be to the staff, intervention participants, your funding source, and other important stakeholders. Many people have a vested interest in the success of your program. Your organization needs to know whether or not your program is successful and, if not, how you plan to improve the program. So, monitoring and evaluation is also used for program improvement. Collecting monitoring and evaluation data will help your organization to maintain quality control and to continuously improve the delivery of your *Project AIM* intervention.

All organization staff involved in the *Project AIM* intervention should be familiar with how to monitor and evaluate the intervention. This includes *Project AIM* program managers, monitoring and evaluation coordinators, and facilitators. While this field guide is not intended for use by community stakeholders, the results of program monitoring and evaluation can be shared with others who are invested in the success of the *Project AIM* intervention in your community.

Benefits of Program Monitoring and Evaluation

Program monitoring and evaluation have become important routine activities in HIV prevention. In the same way that *Project AIM* should be made a part of your organization's routine HIV prevention services, monitoring and evaluation should be performed as part of the delivery of any HIV prevention program. Findings from monitoring and evaluation provide the means for you and your organization to strengthen and improve outcomes for your participants.

There are many reasons to conduct program monitoring and evaluation. In general, monitoring and evaluation will allow your organization to:

- Determine if you are reaching your *Project AIM* targets
- Determine whether your *Project AIM* intervention is working as intended
- Determine whether the *Project AIM* intervention content and activities are being delivered with fidelity
- Determine accountability for funds and resources
- Improve program operations to sustain your *Project AIM* intervention within your organization.

More specifically, program monitoring and evaluation can help your organization learn about:

- Recruitment
- Characteristics of adolescents who participated in the intervention
- The extent of adolescent participation
- How the intervention was delivered
- Outcomes the adolescents experienced

By taking your time for program monitoring and evaluation, you can demonstrate to your stakeholders, including intervention participants, that you are doing your best to deliver *Project AIM* for the benefit of at-risk adolescents.

Process Monitoring

Process monitoring is a fundamental monitoring and evaluation activity. Process monitoring is defined as the process of collecting data that describes the characteristics of the population served, the services provided, and the resources used to deliver those services. These data also focus on which activities are being conducted, what content is being provided, and what resources are used during delivery of your intervention.

Process monitoring answers questions such as:

- How many adolescents were recruited for the *Project AIM* intervention?
- How many adolescents participated in the *Project AIM* intervention?

- How many targets were reached?
- What are the demographic characteristics of the adolescents participating in the *Project AIM* intervention?
- How many *Project AIM* sessions were conducted?
- Which activities were implemented?
- What resources were used to deliver the *Project AIM* intervention?

Process Evaluation

Process Evaluation is the next step in monitoring and evaluating your *Project AIM* intervention. Process evaluation determines the actual performance of your *Project AIM* intervention. Process evaluation involves collecting detailed data about how *Project AIM* was delivered to determine if it was delivered as intended.

Process evaluation compares the population you intended to reach with the actual population served. It also compares how the intervention is supposed to be delivered to what was actually delivered. It is this activity that helps you check whether your process objectives are being met.

Process evaluation can help you answer questions like:

- Were we able to recruit and enroll the intended number of adolescents?
- Did the number of adolescents who actually participated match the targeted number?
- Did the characteristics of the adolescents participating match the intended target population?
- Did we deliver the number of *Project AIM* sessions as intended?
- Did facilitators deliver the intervention with fidelity?

Process evaluation also involves *quality assurance*. It helps you to ensure that you are delivering *Project AIM* as intended and not an unproven variation of the effective intervention. This portion of the monitoring and evaluation plan can also be used as a management tool to help supervisors and staff to do the best job possible. Examples of how to monitor fidelity to your *Project AIM* intervention include:

- Direct observation
- Participant feedback
- Review of reports or notes made by facilitator either during or after the session
- Regular staff meetings

For *Project AIM*, monitoring fidelity to the core elements and intervention activities are considered quality assurance activities. Core elements are required components that represent the theory and internal logic of the intervention and most likely produce the

intervention's main effects. It is crucial for organizations to maintain fidelity to the intervention's core elements and intended activities. *Project AIM* has eight core elements. It is important to know whether each core element and each intended activity was followed or conducted as described in the Implementation section of this guide. Examples of quality assurance and questions about fidelity to the *Project AIM* intervention that your organization can answer using the Process Evaluation forms include:

- Was each Core Element presented as described in the Section I of this document?
- Did the facilitator deliver the intervention as presented in the *Facilitator's Handbook*?
- Did the facilitator use the intervention materials correctly?

If the intervention was not delivered according to the core elements and the *Facilitator Handbook*, you will want to keep track of which changes were made, how were they made, and why. In addition, you might also want to assess whether changes were made in the key characteristics – these are also described in the Section I of this document.

There are many levels of monitoring and evaluation. Organizations must take care when collecting information from participants, as this may be considered "research" and falls under specific guidelines for protection of participants.

Additional monitoring and evaluation should not be done without guidance from CDC regarding research for program evaluation purposes. Please do not create or use forms for collection of outcome data without CDC guidance. Selection of instruments that best measure changes in these risk behaviors and study protocols designed to protect participants involve specific expertise in research methods. Additionally, an independent ethics review board must examine the measures intended to be used to collect information from adolescents to ensure that you are able to protect their privacy and are not putting the adolescents at risk for any harm. Please seek further guidance from your CDC liaison regarding outcome evaluation.

Using Process Monitoring and Evaluation Forms

Monitoring and Evaluation Tool	Purpose	Who Completes	When to Complete
Participant Information Form	Collects demographic information and the number of adolescents who participate in Project AIM	Facilitator	At the start of each session
Facilitator Assessment Form	Assesses adolescents-facilitator interaction, quality of session content, and facilitator perspective on how the session went	Facilitator	Immediately following a session or after all sessions are completed for the day
Fidelity Observation Form	Captures whether or not and activity was done completely and correctly.	Program Manager and/or Monitoring and Evaluation Coordinator	During the delivery of a session and immediately after a session
Quality Assurance Tracking Form	Keeps track of which groups and sessions the Program Manager had observed	Program Manager and/or Monitoring and Evaluation Coordinator	Immediately following each session
What's Your Opinion? Adolescents Evaluation Form	Captures adolescents' opinions overall, the materials, and how engaging the facilitators were perceived to be	Adolescents Participants	Session 12
Project AIM Group Summary Sheet/Project AIM Summary Sheet	Summarizes key data from each group as well as all groups implemented over the same time period by one facilitator pair	Program Manager	After a Project AIM cycle

Project AIM Participant Information Form

Implementing Partner: _____ Start Date:_____ Site: _____

Wave # _____ Group # _____ Facilitator 1 _____ Facilitator 2 _____ End Date_____

Adolescents: Initials and Surname	Consent Signed?	Age	Gender	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															
13.															
14.															
15.															
16.															
17.															
18.															

PROJECT AIM Facilitator Self-Assessment Form

Session 1: What is a Legacy?
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Introduction/Ice Breaker	Yes	No	Had adolescents introduce themselves
	Yes	No	Conducted 'stand up-sit down' activity
2. Group Agreements	Yes	No	Explained importance of Group Agreements
3. What is my Legacy?	Yes	No	Passed out workbook and had adolescents sign name
	Yes	No	Asked who they recognized from legacy poster
	Yes	No	Gave definition of *building a legacy*
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____
_____
_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____
_____
_____

3) Did an activity go especially well? Why?

_____
_____
_____

4) What changes were made to the session? Why?

_____
_____
_____

PROJECT AIM Facilitator Self-Assessment Form

Session 2: Looking Ahead to My Future
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Web Chart: Positive and Negative Futures	Yes	No	Shared experiences with to-do task, 3-5 min
	Yes	No	Wrote adolescents suggestions on web poster for a POSITIVE and NEGATIVE future
	Yes	No	Discussed differences between a positive and negative future
	Yes	No	Discussed obstacles to a successful future
2. Practices for Self-Confidence	Yes	No	Explained Practices for Building Self-Confidence, referred to poster
	Yes	No	Gave adolescents the self-confidence card and key chain
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

_____

3) Did an activity go especially well? Why?

_____

_____

4) What changes were made to the session? Why?

_____

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 3: Guest Speaker
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Guest Speakers and Note-taking	Yes	No	Explained guest speaker and note-taking worksheet
	Yes	No	Introduced speaker(s)
	Yes	No	Monitored guest speaker(s)
2. Thank-You Letters	Yes	No	Explained Thank You Letter Guide and had adolescents write Thank-You Letters

1) Were there any challenges with any of the activities? Why?

_____
_____
_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____
_____
_____

3) Did an activity go especially well? Why?

_____
_____
_____

4) What changes were made to the session? Why?

_____
_____
_____

PROJECT AIM Facilitator Self-Assessment Form

Session 4: What Lifts Me Up, What Holds Me Back?
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Color Block Activity	Yes	No	Shared experiences with to-do task, 3-5 min
	Yes	No	Defined *positive influence* and *negative influences*; asked for examples
2. Influences in MY Life	Yes	No	Had adolescents participate in *Influences in MY Life*
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____
_____
_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____
_____
_____

3) Did an activity go especially well? Why?

_____
_____
_____

4) What changes were made to the session? Why?

_____
_____
_____

PROJECT AIM Facilitator Self-Assessment Form

Session 5: Expressing Myself in My Future Career
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Career Puzzle	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Defined *career*
	Yes	No	Had adolescents participate in Career Puzzle Game
2. Career Interest Inventory	Yes	No	Explained the Career Rainbow booklet
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____
_____
_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____
_____
_____

3) Did an activity go especially well? Why?

_____
_____
_____

4) What changes were made to the session? Why?

_____
_____
_____

PROJECT AIM Facilitator Self-Assessment Form

Session 6: Exploring My Future
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Making My Choice	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Reviewed career reports
	Yes	No	Made connections between career report and *Making My Choice* worksheet
	#		Number of individual interviews completed?
2. Career Aspiration and Discussion	Yes	No	Explained *Aspiration Declaration*
	Yes	No	Signed Aspiration Declaration for each adolescent
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

_____

3) Did an activity go especially well? Why?

_____

_____

4) What changes were made to the session? Why?

_____

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 7: What Does Today have to do with My Future?
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. My Personal Work Experience	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Had adolescents complete and share Personal Experience worksheet
	#		Number of Individual Interviews completed?
2. It's My CV	Yes	No	Gave definition and discussed concept of Resume/CV
	Yes	No	Explain Resume/CV worksheet
	Yes	No	Assigned *to-do* task
	#		Number of Individual Interviews completed?

1) Were there any challenges with any of the activities? Why?

_____

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

_____

3) Did an activity go especially well? Why?

_____

_____

4) What changes were made to the session? Why?

_____

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 8: What can I do NOW to Get There?
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. What can I do NOW to get there?	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Discussed future goals
	Yes	No	Explained *What Can I do NOW to get there?*
	#		Number of individual interviews completed?
2. Designing my business card	Yes	No	Showed examples of business cards
	Yes	No	Passed around Directory of Images
	Yes	No	Assigned *to-do* task
	Yes	No	Number of Individual Interviews completed?

1) Were there any challenges with any of the activities? Why?

_____

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

_____

3) Did an activity go especially well? Why?

_____

_____

4) What changes were made to the session? Why?

_____

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 9: Expressing Myself in Communication and Relationships
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Peer Pressure	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Discussed negative peer pressure
2. Choosing my style and acting it out	Yes	No	Explained *Choose My Style* and referred to poster
	Yes	No	Role-played different communication styles
	Yes	No	Divided adolescents into groups and distributed cards
	Yes	No	Discussed communication styles after each group role-play
	Yes	No	Linked communication styles to future goals
	Yes	No	Assigned *to-do* task

1) Were there any challenges with any of the activities? Why?

_____

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

_____

3) Did an activity go especially well? Why?

_____

_____

4) What changes were made to the session? Why?

_____

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 10: My Dream Home
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. My Dream Home	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Provided adolescents with materials, gave 5 min to look over
	Yes	No	Discussed planning a home using *Planning Your Dream Home*
	Yes	No	Gave adolescents 15 minutes to design their home
	Yes	No	Invited adolescents to present their home
	#		Number of Individual Interviews completed?
2. Imagining my future	Yes	No	Did guided imagery
	Yes	No	Had adolescents complete *Imagining My Future*
	Yes	No	Discussion on *Imagining My Future* activity
	Yes	No	Assigned *to-do* task
	Yes	No	Number of Individual Interviews completed?

1) Were there any challenges with any of the activities? Why?

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

3) Did an activity go especially well? Why?

_____

4) What changes were made to the session? Why?

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 11: Choosing My Future
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. My Timeline	Yes	No	Shared experiences with *to-do* task, 3-5 min
	Yes	No	Defined timeline
	Yes	No	Explained *My Timeline* using an example on *My Timeline* poster
	Yes	No	Had adolescents fill in *My Timeline* worksheet
	Yes	No	Provided an example of a detour on *My Timeline* poster
	Yes	No	Had adolescents add detours on *My Timeline* worksheet
	Yes	No	Asked for volunteers to share timelines
	Yes	No	Number of Individual Interviews complete?
2. Planning My Next Steps	Yes	No	Had adolescents complete *Planning My Next Steps* worksheet
	Yes	No	Reminded adolescents of upcoming graduation

1) Were there any challenges with any of the activities? Why?

_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____

3) Did an activity go especially well? Why?

_____

4) What changes were made to the session? Why?

_____

PROJECT AIM Facilitator Self-Assessment Form

Session 12: Pulling It All Together
Date:_____ **Location:**_____ **Facilitator 1:**_____ **Facilitator 2:**_____

Did you complete the following activities? Circle "yes" or "no".

1. Letter of Recommendation & Portfolio	Yes	No	Distributed *Letter of Recommendation*
	Yes	No	Distributed portfolios
	Yes	No	Distributed adolescents business cards
	Yes	No	Distributed completed work
	Yes	No	Had adolescents organize portfolios with completed work
2. Graduation	Yes	No	Handed out Graduation Certificates

1) Were there any challenges with any of the activities? Why?

_____
_____

2) What activity was skipped? Why? (e.g., group too large, missing materials, etc.)

_____
_____

3) Did an activity go especially well? Why?

_____
_____

4) What changes were made to the session? Why?

_____
_____

PROJECT AIM Fidelity Observation Form - SESSION ONE: What is a Legacy?

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____
Facilitator 1_____ Facilitator 2_____
Facilitator 1 Gender_____ Facilitator 2 Gender_____
Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions <u>while observing the session</u>. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions <u>after the session is completed.</u>

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION TWO: Looking Ahead to My Future

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION THREE: Guest Speakers

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION FOUR: What Lifts Me Up, What Holds Me Back?

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____
Facilitator 1_____ Facilitator 2_____
Facilitator 1 Gender_____ Facilitator 2 Gender_____
Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION FIVE: Expressing Myself in My Future Career

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____
Facilitator 1_____ Facilitator 2_____
Facilitator 1 Gender_____ Facilitator 2 Gender_____
Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION SIX: Exploring My Future

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION SEVEN: What does Today have to do with My Future?

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION EIGHT: What Can I Do NOW To Get There?

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION NINE: Expressing Myself in Communication & Relationships

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer.

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION TEN: My Dream Home

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer.

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION ELEVEN: Choosing My Future

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Fidelity Observation Form - SESSION TWELVE: Putting It All Together

Site Name_____ Observer Name_____ Date:_____ Start Time:_____ End Time:_____

Facilitator 1_____ Facilitator 2_____

Facilitator 1 Gender_____ Facilitator 2 Gender_____

Facilitator 1 Age_____ Facilitator 2 Age_____

Complete the following questions while observing the session. Check "yes" or "no". Explain your answer

Did the facilitators:			
Read script boxes or closely paraphrases; Maintain fidelity	**Yes**	**No**	
Encourage adolescents to share their ideas and participate; engage adolescents	**Yes**	**No**	

Did most adolescent participants:				
Interact positively with and listen to facilitators	**Yes**	**No**		
Understand the activity	**Yes**	**No**		
Actively engage in the activity	**Low**	**Mid**	**High**	

Complete the following questions after the session is completed.

Did the facilitator:			
Co-facilitate the intervention	**Yes**	**No**	
Prepare for the session; Utilize session materials	**Yes**	**No**	What materials were used?
Describe the environment where the session took place. Total # of Girls_____ Total # of Boys_____			

PROJECT AIM Quality Assurance Tracking Form

The purpose of this form is to help program managers keep track of which groups and sessions they have observed.

- It is recommended that at least 2 sessions per group be observed during a six week training period.
- Observer tries to observe various sessions being facilitated to different groups.
- Observer writes initials and date of observation in the applicable Session Block.

	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
Gp 1												
Gp 2												
Gp 3												
Gp 4												
Gp 5												
Gp 6												
Gp 7												
Gp 8												
Gp 9												
Gp 10												

What's Your Opinion?

Please use the scale below to let us know how much you agree or disagree with these statements about Project AIM. Your opinion helps us make Project AIM better

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Project AIM facilitators helped me to participate.				
2. The facilitators let me know that what I have to say matters.				
3. Project AIM facilitators were a positive influence on me.				
4. Being in Project AIM was helpful to me.				
5. Project AIM helped me think about my future				
6. I talk to my parent(s) or another adult about Project AIM and my future.				
7. Project AIM motivates me to stay out of trouble.				
8. Project AIM makes me feel like I can succeed.				

PROJECT AIM Group- & Summary Report

INSTRUCTIONS

Introduction
This Excel workbook has been designed to assist Project Managers in summarizing key process monitoring data for *Project AIM.* Each workbook summarizes key data for every group per wave of implementation for one facilitator pair. A new workbook should be created for each implementation wave per facilitator pair. For example, if there are 3 pairs of facilitators delivering *Project AIM,* you would complete 3 Excel workbooks (one for each pair). When the 3 pairs begin their next wave of implementation, you will create and complete 3 new workbooks.

Group Tabs
At the bottom of this workbook there are 4 'Group' tabs. Each group tab represents one Group that a particular facilitator pair leads during the course of the implementing wave. For example: Group 1 may be the group that meets on Monday- and Wednesday afternoons, Group 2 meets on Tuesday- and Thursday afternoons, etc. Only use as many Group tabs as there are groups for a particular facilitator pair. For example, if one of your facilitator pairs delivers *Project AIM* to only one group of participants each week, you will only fill in the first group tab, leaving the other 3 blank.

Summary Report
The Summary tabs is the last tab at the bottom of this workbook and is located to the right of the 'Group 4' tab. Clicking on this tab will bring up the Summary Report. This report automatically sums the information you have inserted in the Group tabs to give you a summary report of key data for all of the groups for each facilitator pair.

Inputs

Group Tab
When you click on a Group tab, you will see cells that are coloured in shades of blue – these are the cells that you would have to enter information into.
The following blue cells have to be completed in the Group tab:
Implementing Organization: Type in the name of your organization.
Province: Type in the name of the province where the implementing site is located.
District: Type in the name of the district where the implementing site is located.
Location: Type in the name of the city, town, village or community in which the group takes place.
Sub-location: This is an optional cell to more specifically describe the location of where the group takes place.
Wave: Give each wave a distinct number. For example: Wave 1 would be the first wave of implementation. Do not repeat numbers across waves.
Group: Give each group a distinct number. For example: Group 1 would be the Monday afternoon group for facilitator pair 1 for wave 1 of implementation. Do not repeat numbers across waves or across facilitator pairs.

Days of the week the sessions are held: For these two cells, click on the cell, then click on the down arrow that appears and select the days of the week of that *Project AIM* group.
Facilitator 1 & 2: Type in the names and surnames of the two facilitators.
Gender: For these two cells, click on the cell, then click on the down arrow that appears and select the gender of each facilitator.

Participation and Retention:
Date: The date of each session should be filled in following a dd-mm-yy format. For example: 09/01/13 (9 January 2013).
Nr participants who completed session: Type in the number of participants who completed that session. Note: This does not include those adolescents that miss session 5 or 6 but meet with facilitators to complete the activity. If a large make-up session was offered, any adolescents attending that session should be counted as having competed the session.
Nr participants who completed 9, 10 or 11 of the 12 sessions: Type in the number of participants who completed 9 or 10 or 11 sessions but not all 12.
Who were male and female: In the first cell, type in the number of participants who completed 9 or 10 or 11 sessions but not all 12 who are **male.** In the second cell, type in the number of participants who completed 9 or 10 or 11 sessions but not all 12 who are **female.** For example: 8 participants completed 9 or 10 or 11 sessions but not all 12 sessions. Of the 8, 3 participants were males and 5 participants were females.
Nr participants who completed all 12 sessions: Type in the number of participants who completed ALL 12 sessions.
Who were male and female: In the first cell, type in the number of participants who completed ALL 12 sessions who are **male.** In the second cell, type in the number of participants who completed ALL 12 sessions who are **female.** For example: 10 participants completed ALL 12 sessions. Of the 10, 4 participants were males and 6 participants were females.
Retention rate: The retention rate will automatically be generated by dividing the number who completed ALL 12 sessions by the number that completed Session 1.

Demographic Information:
Nr of 11 year old participants who completed all 12 sessions: Type in the number of participants who completed ALL 12 sessions who were 11 year old. For example: 10 participants completed ALL 12 sessions, with 4 of them being 11 year old.
Male or Female: Type in the number of 11 year old participants who completed all 12 sessions who were male or female. For example: 4 participants were 11 years old of which 2 were males and 2 were females.
Nr of 12 year old participants who completed all 12 sessions: See above.
Nr of 13 year old participants who completed all 12 sessions: See above.
Nr of 14 year old participants who completed all 12 sessions: See above.
Participant Satisfaction: Summarize the *What's Your Opinion* questionnaire by typing in the number of participants who selected each category. For example: If 4 participants marked the 'Agree' box for question 1, type in a '4' in the 'Agree' box. Note: Only indicate the responses of participants who have completed ALL 12 sessions.

Summary Tab:
When you click on the 'Summary' tab, you will see pink boxes. Most of these boxes will automatically tally from the group boxes. You do not have to fill them in.
You will have to complete the following boxes:
Implementing organization: Type in the name of the implementing organization.
Wave: Type in the wave number.
Wave dates: Type in the date that the wave started and the date that the wave finished using the format dd-mm-yy. For example: 09/07/11 – 30/08/11.

Facilitators:
Facilitator 1& 2: Type in the names and surnames of the facilitators.
Gender: For these two cells, click on the cell, then click on the down arrow that appears and select the gender of each facilitator.

Barriers of Challenges facilitators faced when implementing the sessions.
This box is for you to type any barriers or challenges facilitators faced when implementing the sessions. Make sure that you indicate for which group or facilitators your comments are applicable. Information for this box comes from debriefing sessions with the facilitators and Intervention Fidelity Observation Forms.

Anything Else. This final box allows you to type anything else you think is important to note about the *Project AIM* groups and the implementation of the sessions that was not included elsewhere. For example: Providing what participants (or other stakeholders) may say about their experience of *Project AIM.*

Submitting Workbook

After an implementing wave is complete, fill in this Excel workbook for each of the facilitator pairs and submit it electronically to your CDC Project AIM officer.

PROJECT AIM Group Summary Sheet

Implementing Organization:

Location of Project AIM delivery:

Province: District:

Location: Sub-location:

Wave: **Group :** **Days sessions are held:** and

Facilitators:

Facilitator 1: Gender: Male

Facilitator 2: Gender: Male

Participation and Retention:

Session 1:	Date:		Nr participants who completed Session 1
Session 2:	Date:		Nr participants who completed Session 2:
Session 3:	Date:		Nr participants who completed Session 3:
Session 4:	Date:		Nr participants who completed Session 4:
Session 5:	Date:		Nr participants who completed Session 5:
Session 6:	Date:		Nr participants who completed Session 6:
Session 7:	Date:		Nr participants who completed Session 7:
Session 8:	Date:		Nr participants who completed Session 8:

Session 9:	Date:		Nr participants who completed Session 9:	
Session 10:	Date:		Nr participants who completed Session 10:	
Session 11:	Date:		Nr participants who completed Session 11:	
Session 12:	Date:		Nr participants who completed Session 12:	

Nr participants who completed 9, 10 or 11 of the 12 sessions: who are Male: Female:

Nr participants who completed all 12 sessions: who are Male: Female:

Retention rate: #DIV/0!

Demographic Information:

Summarize the Demographic Information below by indicating the number of participants who completed all 12 sessions:

Nr of 11 years old participants who completed all 12 sessions:		Male:	Female:
Nr of 12 years old participants who completed all 12 sessions:		Male:	Female:
Nr of 13 years old participants who completed all 12 sessions:		Male:	Female:
Nr of 14 years old participants who completed all 12 sessions:		Male:	Female:

Participant Satisfaction:

Summarize the 'What's Your Opinion' questionnaire by indicating the number of participants completing all 12 sessions who marked each category. For example: If 4 participants marked the 'Agree' box of question 1, type a "4" in

the 'Agree' box below.

1. Project AIM facilitators helped me to participate.

Strongly Agree	Agree	Disagree	Strongly Disagree

2. The facilitators let me know that what I have to say, matters.

Strongly Agree	Agree	Disagree	Strongly Disagree

3. Project AIM facilitators were a positive influence on me.

Strongly Agree	Agree	Disagree	Strongly Disagree

4. Being in Project AIM was helpful to me.

Strongly Agree	Agree	Disagree	Strongly Disagree

5. Project AIM helped me think about my future.

Strongly Agree	Agree	Disagree	Strongly Disagree

6. I talk to my parent(s) or another adult about Project AIM and my future.

Strongly Agree	Agree	Disagree	Strongly

			Disagree

7. Project AIM motivates me to stay out of trouble.

Strongly Agree	Agree	Disagree	Strongly Disagree

8. Project AIM makes me feel like I can succeed.

Strongly Agree	Agree	Disagree	Strongly Disagree

PROJECT AIM Summary Sheet

Implementing Organization:

Wave:

Wave dates:

Facilitators:

Facilitator 1:

Gender: Female

Facilitator 2:

Gender: Female

Participation and Retention:

Total nr of groups facilitated this wave:

Total nr of participants completing session 1: 0

Total nr participants who completed 9, 10 or 11 of the 12 sessions: 0 Male: 0 Female: 0

Total nr participants who completed all 12 sessions: 0 Male: 0 Female: 0

Overall retention rate: #DIV/0!

Demographic Information:

Total nr of 11 years old participants who completed all 12 sessions:	0	Male:	0	Female:	0
Total nr of 12 years old participants who completed all 12 sessions:	0	Male:	0	Female:	0
Total nr of 13 years old participants who completed all 12 sessions:	0	Male:	0	Female:	0
Total nr of 14 years old participants who completed all 12 sessions:	0	Male:	0	Female:	0

Participant Satisfaction:

Summarize the 'What's Your Opinion' questionnaire by indicating the TOTAL number of participants in all groups completing all 12 sessions who marked each category.

1. Project AIM facilitators helped me to participate.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

2. The facilitators let me know that what I have to say, matters.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

3. Project AIM facilitators were a positive influence on me.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

4. Being in Project AIM was helpful

to e.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

5. Project AIM helped me think about my future.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

6. I talk to my parent(s) or another adult about Project AIM and my future.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

7. Project AIM motivates me to stay out of trouble.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

8. Project AIM makes me feel like I can succeed.

Strongly Agree	Agree	Disagree	Strongly Disagree
0	0	0	0

Appendix A: PROJECT AIM Recruitment Form (Adolescents)

Location: _____**Date:** [_] [_]/ [_] [_]/ [_] [_]
dd mm yy

Adolescents' Name:	
Adolescents' Age:	
Adolescents' Gender:	**Circle:** **Male Female**
Adolescents' School and Grade:	**School:**
	Grade:
Phone Number:	
Address:	
Parent/Guardian Name:	

How do you prefer to be contacted?

- ❑ Through school
- ❑ At home
- ❑ By phone
- ❑ Other (specify):_____

If Applicable:

How did you hear about the *Project AIM* Program?

- ❑ Through school
- ❑ Flyer
- ❑ Radio advertisement
- ❑ Friend
- ❑ Organization
- ❑ Other (specify):_____

Appendix A: PROJECT AIM Recruitment Form (Parent/Guardian)

Location: _____ **Date:** [_] [_]/ [_] [_]/ [_] [_]
dd mm yy

Parent/Guardian Name: _____ **Parent/Guardian Gender:**_____

1. Are you a parent or guardian of a child between the ages 11–14 years?	**o Yes o No**
2. Are you a local resident?	**o Yes o No**
3. Does your child speak the local language?	**o Yes o No**
4. Are you willing to allow your child to attend and participate in all twelve sessions?	**o Yes o No**
ELIGIBLE? *(Child is eligible if parent/guardian responded "yes" to questions 1-4)*	**o Yes o No**

IF NOT ELIGIBLE: *Unfortunately, your child is not eligible to participate in the intervention. Since the program was researched and tested with a specific audience, all program participants must have certain characteristics for the program to be effective. We appreciate the time you have taken to speak with us. Thank you.*

IF ELIGIBLE, ASK QUESTION 5:

5. Would you like your child to participate in the Project AIM program?	**o Yes o No**

IF YES: *I am glad that you are interested in having your child joining us!*

- Review the session schedule with the interviewee.
- Explain the importance of the child attending all sessions.
- Explain that a Parent/Guardian Permission Form has to be completed for the child to attend the Project AIM program.

Request and confirm contact information so the parent/guardian and child can be reached.

Appendix B: Parent/Guardian Permission Form

Parent/Guardian Permission Form

I agree to let my child participate in *Project AIM* being offered by _____ (name of organization) at _____ (site) on _____ and _____ (days) at _____ (time). *Project AIM* will start on_____(date) and will run for approximately 6 weeks.

I understand that if my child participates in *Project AIM*, there will be discussions about planning for the future, careers, communication skills, identifying influences in their lives that may support or hinder their future opportunities.

I understand that all discussions that my child will have with the facilitators of *Project AIM* will be kept confidential and will not be reported to me or anyone else.

I give permission for my child to participate in *Project AIM.* I understand that she/he is free to stop at any time.

Child's name _____

Age _____

Parent/Guardian's signature _____

Date _____

Address _____

Contact number _____

Appendix C: PROJECT AIM Attendance Policy

Project AIM consists of 12 sessions. Each session builds on the previous session and missing a session undermines the ability of the adolescents to fully participate and gain from the intervention. Participants should therefore be encouraged to attend all 12 sessions.

'New' participants must attend Session 1. Unexpected events, such as illness, do occur, and exceptions may be made on a case by case basis. However, if an exception is made, the adolescents must attend by Session 2 to be registered for that cycle of *Project AIM*. Adolescents that still wish to join should be put on a waiting list for the next cycle. The first session is critical in that it lays the foundation, builds group cohesion and sets the tone for the rest of the intervention.

Sessions should start on time. The starting time should take the community's and participants' needs into consideration, or as agreed between the adolescents and facilitators during Session 1 and indicated in the Group Agreement.

In order to attend graduation (Session 12) and receive a portfolio and certificate, adolescents may not miss more than 3 sessions prior to Session 12. In other words, they must attend at least 8 sessions between Sessions 1 and 11. If adolescents miss more than three sessions prior to Session 12, facilitators should explain to adolescents that they have not completed enough of the program to graduate, and suggest that they join the next cycle of *Project AIM*. It is important that facilitators discuss attendance with adolescents from the beginning, and talk privately with adolescents who begin missing sessions as soon as possible.

If a adolescents misses 0, 1 or 2 sessions of *Project AIM*, but then also misses Session 12, facilitators may still 'graduate' the adolescents in a make-up of session 12 by guiding the adolescents as he/she builds his/her portfolio and then issue him/her the certificate.

Adolescents should strongly be encouraged not to miss Sessions 5 and 6. Should a participant miss Session 5, the facilitator should ensure that he/she spends 5 – 10 minutes with the adolescents before Session 6 explaining how to complete the *Career Rainbow*. The adolescents have to complete the worksheets and the facilitator has to produce a personalized career report before the session starts as it is an integral part of Session 6.

Should a participant miss Session 6, the facilitator should provide adolescents with the career reports and assist adolescents in completing the *Career Aspiration Declaration* worksheet, then sign as a witness. The adolescents should verbalize the career aspiration to the facilitator.

Even if a adolescents make's up the activities outlined above for Sessions 5 and 6, missing one or both of these sessions still counts towards the maximum of three sessions adolescents can miss and still graduate AIM with certificate and portfolio.

If adolescents misses one of the other sessions (besides 5 and 6), they do not have to make up these sessions as most of these activities are meant to be done in groups within the context of the other adolescents.

If a large number of adolescents have missed a session for an acceptable reason, facilitators may consider having a special make-up session where the entire session is repeated for those who have missed it. If the full make-up session is done with a group of adolescents, this session will not count as 'missed' towards an adolescents' maximum of 3 absences prior to graduation.

To be counted as 'reached', adolescents should attend at least 9 of the 12 sessions. Adolescents who miss 3 sessions prior to Session 12 may not attend Session 12, and thus may not be counted as 'reached'.

Appendix D: CDC Information Materials

Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are (1) the Centers for Disease Control and Prevention (CDC) factsheet on male latex condoms, (2) the CDC Statement on Study Results of Product Containing Nonoxynol-9, (3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9 Spermicide Contraception Use—United States, 1999," (4) the ABCs of Smart Behavior, and (5) the CDC guideline on the content of the HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

Condoms and STDs: Fact Sheet for Public Health Personnel

Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.

Sexually Transmitted Diseases, Including HIV Infection

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or

HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs, however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e. new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

HIV infection is, by far, the most deadly STD, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual

transmission of HIV is both comprehensive and conclusive. The ability of latex condoms to prevent transmission of HIV has been scientifically established in "real-life" studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as urethral and vaginal secretions, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms provides a high degree of protection.

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

Latex condoms, when used consistently and correctly, reduce the risk of transmission of STDs such as gonorrhea, chlamydia, and trichomoniasis.

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against diseases such as gonorrhea, chlamydia, and trichomoniasis by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through "skin-to-skin" contact from sores/ulcers or infected skin that

looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/secretions. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are covered (protected by the condom) as well as those areas that are not.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine.

Page last reviewed: April 6, 2011
Page last updated: September 13, 2011
Content source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

MMWR™

Weekly

August 11, 2000 / 49(31);717-8

Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*1*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, http://www.cdc.gov/hiv; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

* Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

MMWR™

Weekly

May 10, 2002 / 51(18);389-392

Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (*1*), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (*2--4*); one trial showed an increased risk (*3*). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (*5*, *6*), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (*4*,*6*,*7*), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (*8*). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (*7*). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (*7*).

Spermicidal gel is used in conjunction with diaphragms (*1*); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (*1*).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (*9*). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (*1*). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (*2*,*7*). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contracept X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms No.	Male condoms (%)	N-9 products† No.	N-9 products† (%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	**4,315,040**	**527,248**	**(12)**	**92,997**	**(2)**

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, V Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Lo Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Ut Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=A Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphr suppositories.

Table 2

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/te

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods			
		Condoms with N-9	Condoms without N-9	Gel	Vaginal Film	Vaginal Insert	Jelly
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756
Michigan	166,893	631,000	254,000	0	0	NA	1,000
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200
Oregon	57,099	151,900	276,000	345	25,764	2,074	272

* Not available.
† 41 of 61 grantees responded.
§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.

Appendix E: PROJECT AIM Services/Resource List

Organization Name	Field of Work	Contact Number	Primary Clients

Project AIM

Project AIM is a group-level, adolescent development intervention designed to reduce HIV risk behaviors by providing adolescents with the motivation to make safe choices and to address deeper barriers to sexual risk prevention. Adolescents are motivated to achieve a positive future and avoid a negative future.

Project AIM helps and encourages adolescents:

- **To understand the concept of legacy through the use of role models**
- **See a picture of themselves in the future as successful adults**
- **Set goals to achieve their desired future selves**
- **Identify strengths and resources needed for future success**
- **Build effective communication skills**
- **Protect their future through reducing risk behaviors today**

For more information contact:

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